



Introduction

Member's Application for Disability Retirement

Form Last Revised: February, 2020

Before you file an application for a disability retirement allowance, please note that you should:

- Contact your retirement board. This is an important step in ensuring that you have all of the information that you need. The staff at your retirement board will help you understand the process and respond to your questions throughout the process.

Read the *Guide to Disability Retirement for Public Employees*

- www.mass.gov/perac
- This guide will give you general information about the disability process. Your retirement board can furnish you with a copy of this guide.

Next Step

- Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to your retirement board. If your application is incomplete, the application process will be delayed. Until all of the required information has been submitted, your retirement board cannot assign a date of application, which will be very important in determining your effective date of retirement and retirement allowance date.
- Your retirement board can prepare an estimate of your retirement allowance for planning purposes at any time, but an official retirement allowance cannot be calculated until your application has been approved. If your application is approved, you may need to submit additional documents, including, if applicable, your marriage certificate, your spouse's birth certificate, and your dependent children's birth certificates.
- Before you send your application and your documents to your retirement board, make a photocopy of them for your own records.

Your Retirement Board Will:

- Request information from your employer, your personal physician, and the other physicians, hospitals, and insurance companies that you identified on your application.
- You may, if you wish, submit the Physician's Statement to your primary treating physician. If you choose to do so, let your retirement board know so that duplication of effort can be avoided.

Next Step

- When all the information specified above has been received by your retirement board, the application package is considered complete and your retirement board will decide whether to ask the Public Employee Retirement Administration Commission (PERAC) to set up a three member regional medical panel to examine you.



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Timeframes

- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.
- You will be given a 14 day notice of the scheduled examination(s).
- The regional medical panel will report their findings and recommendations to PERAC within 60 days after completing their examination(s).
- Within 5 days of receipt of a properly completed medical panel report, PERAC will forward the report to your retirement board.
- Your retirement board has the option at this point of requesting further information or a clarification from the regional medical panel if they determine that it would be helpful.
- Within 30 days of receipt of the report, your retirement board will notify you of the panel's findings and provide you with a copy of all of the documents completed by the regional medical panel.
- If the regional medical panel precludes retirement for the disability you claimed, your retirement board could either deny your application or it could ask PERAC for a new regional medical panel if the board believes that circumstances warrant it.

If PERAC declines to schedule a new examination, your board will deny your application.

- If the regional medical panel findings permit retirement for the disability claimed, your retirement board shall determine whether or not to approve the application.
- A hearing may be held on any disability retirement application and shall be held upon your request.
- If a hearing is scheduled, your board must give you at least a 30 day notice of the time and place for the hearing and the issues involved.
- Your retirement board's decision about your eligibility for disability retirement must be made no later than 180 days after you file your completed application, unless PERAC grants an extension.
- If your application is approved by your retirement board, it will be transmitted to PERAC for final action. PERAC must act on your application within 30 days of its receipt.
- If your application is denied by your retirement board, your retirement board will advise you of your right to appeal the decision.

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Retirement Board: Please place your address, phone number, fax number and email address here.

Name of Retirement Board:

Address:

City/Town:

Zip Code:

Telephone:

Fax:

Applicant's Information

Applicant's Full Name (First, Middle Initial, Last)

Former or Maiden Name (if different)

***_**_ _ _ _ _

Street Address

Social Security # (last four)

City/Town

State

Zip Code

Phone #

Email

Date of Birth

Place of Birth

Sex

M

F

Are You a Veteran?

YES

NO

If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list your alternate address below.

Alternate Street Address

City/Town

State

Zip Code

Phone #

To:

From:

Dates in Residence at Alternate Address (Fill in To/From Above)

I understand that I have the right to apply for Accidental Disability and/or Ordinary Disability Retirement benefits. If I believe my disability may be the result of a job-related incident or injury, I may apply for Accidental Disability benefits and must answer all of the questions on this application. I will be required to provide evidence that my disability occurred as a result of a personal injury sustained or a hazard undergone while in the performance of my duties at a definite place and time without serious and willful misconduct on my part.

If I apply for Accidental Disability Retirement and PERAC approves my application after considering the Retirement Board's findings, the Regional Medical Panel Report and other evidence, I will be granted an Accidental Disability.

If I apply for an Accidental Disability and PERAC approves an Ordinary Disability application for me based on the Retirement Board's findings, the Regional Medical Panel Report and other evidence, then I may be retired for Ordinary Disability.

I apply to be retired on the basis of:

(Fill in the blank below with **ONE** of the following: **ACCIDENTAL**, **ORDINARY**, or **EITHER** for Accidental or Ordinary Disability)

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information on this application may subject me to loss of my benefits as well as civil and criminal penalties.

Applicant's Signature:

Date:

Disability Type: Member: SSN: ***-**-_____

Statement of Applicant's Duties

In order to receive a disability retirement allowance, a member must be permanently and totally disabled from performing the essential duties of his/her position. Essential duties are those duties or functions of a job or position that must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. In accordance with PERAC's regulations, 840 CMR 10.07, your employer is required to identify the essential duties of your position.

1. Please state the medical condition(s) for which you are filing this application for disability retirement.

2. What is your current position and job title?

3. Is this a temporary or accommodated position?

4. Please describe the duties that you are required to perform in your current position.

5. How frequently are you required to perform these duties?

6. Please describe the duties that you are unable to perform as a result of your disability.

7. When did you cease to be able to perform all of the essential duties of your current position?

Member's Application for Disability Retirement

Disability Type: Member: SSN: ***-**-_____

Your Employment History

Your Current Position (From which you plan to retire)

<input type="text"/>		<input type="text"/>	
Title		Name of Department	
<input type="text"/>		<input type="text"/>	
Employer's Street Address		Name of Head of Department	
<input type="text"/>		<input type="text"/>	
City/Town	State	Zip Code	Employer's Email Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Dates Employed (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	From: <input type="text"/>	To: <input type="text"/>

Your Previous Positions

Please list all previous employment, beginning with your most recent position. Include all prior public and private employment. Please note that, if any other Massachusetts agency or unit has ever employed you, you may be eligible to purchase creditable service for that public sector employment. Contact your retirement board for further information about making such a purchase. If you need additional space, please attach a separate sheet.

<input type="text"/>		From: <input type="text"/>	To: <input type="text"/>
Employer's Name		Dates Employed (Fill in From/To above)	
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street Address	City/Town	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer's Name		From: <input type="text"/>	To: <input type="text"/>
Dates Employed (Fill in From/To above)			
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street Address	City/Town	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer's Name		From: <input type="text"/>	To: <input type="text"/>
Dates Employed (Fill in From/To above)			
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street Address	City/Town	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Employer's Name		From: <input type="text"/>	To: <input type="text"/>
Dates Employed (Fill in From/To above)			
<input type="text"/>		<input type="text"/>	<input type="text"/>
Street Address	City/Town	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Disability Type: Member: SSN: ***-**-_____

Statement About Recent Physical Activities

1. For the period of the last year, please describe your physical activities, including:
 - Medical rehabilitation activities
 - Activities of daily living (for example, driving, cleaning, etc.)
 - Sports or other strenuous activities
 - Other employment since the onset of your disability

G.L. c. 32, § 15

1. Have you been officially investigated for or charged with misappropriation of funds from your employer or convicted of any crime related to your office or position? YES NO
If YES, please provide documentation.

If you are only applying for ordinary disability, you are not required to complete the next section for accidental disability and can skip to page 10.

Member's Application for Disability Retirement

Disability Type: Member: SSN: ***-**-_____

Reason for Accidental Disability

One of the conditions for receiving approval of an application for accidental disability retirement is that your retirement board must find that your disability is the natural and proximate result of either a personal injury you sustained (usually, one or several specific incidents), or a hazard undergone (generally, exposure to a harmful situation over a period of time).

Certain employees may be eligible to apply for an accidental disability benefit under one of three statutory Presumptions described in Massachusetts General Laws, Chapter 32, Sections 94, 94A and 94B. Please direct your questions about your Presumptions to your retirement board.

Please identify the reason for your disability: Personal Injury Hazard Presumption

In describing the personal injury that you sustained or the hazard to which you were exposed, it is important to be as specific as possible.

Medical Condition

1. Date(s):
2. Specific time(s) or if hazard, length of time exposed:
3. Location(s):
4. Description of Incident(s), Hazard, or if applicable, why you are applying under a Presumption:
5. Job duties you were performing at the time of the incident:
6. In your own words, what is the injury(s) sustained as a result of the described incident?

Other Conditions

1. Please describe any other circumstances, events, or physical conditions that contributed or may have contributed to your disability.

Member's Application for Disability Retirement

Disability Type: Member: SSN: ***-**-_____

Incident Reports

Please provide the following information **about each person or agency** with which you filed a report of the injury(ies) that you sustained or the hazard to which you were exposed.

Agency		Name (First, Last, Middle)		
Street Address		City	State	Zip Code
Phone #	Fax #	Email	Date You Filed Report	
Agency		Name (First, Last, Middle)		
Street Address		City	State	Zip Code
Phone #	Fax #	Email	Date You Filed Report	

(Attach additional sheets if necessary)

Witness Data:

For each witness to the incident(s) or hazard(s) that you've described, please provide the following information.

Name (First, Last, Middle)		Phone #	Relationship to You	
Street Address		City	State	Zip Code
Name (First, Last, Middle)		Phone #	Relationship to You	
Street Address		City	State	Zip Code

(Attach additional sheets if necessary)

Member's Application for Disability Retirement

Disability Type: Member: SSN: ***-**-_____

Other Actions Taken

As a result of the incident(s) or hazard(s) that you have described, have you filed a grievance pursuant to a collective bargaining agreement? If **"YES"**, please describe the status of your grievance. YES NO

Did your employer take any administrative or disciplinary action as a result of the Incident(s) or Hazard(s) you have described? If **"YES"**, please describe the current status of your litigation. YES NO

Is there now or has there been, any other litigation in any forum regarding the injury upon which this application is based? If **"YES"**, please describe current the status of your litigation. YES NO

Workers' Compensation

Have you applied for, or are you receiving, or have you received weekly Workers' Compensation benefits or a Workers' Compensation settlement related to your claimed disability? If **"YES"**, please describe the current status of your Workers' Compensation. YES NO

Section 111F Benefits

Have you received or are you receiving benefits, related to your claimed disability, pursuant to Massachusetts General Laws, Chapter 41, Section 111F? If **"YES"**, please describe the current status of your Section 111F Benefit. YES NO

Other Payments

Have you received any other payments, assault, injury, etc. as a result of the injury upon which this application is based? If **"YES"**, please describe the current status of these payments. YES NO

Member's Application for Disability Retirement

Disability Type:
Member:
SSN: ***-**-____

Medical Treatment - Treating Physician

Your retirement board will request a statement certifying your disability status from the physician who is treating you for your disability. Please provide the following information about the physician who has provided you with treatment in connection with your disability.

<input type="text"/>		<input type="text"/>	
Health Care Provider's Name		Hospital/Facility	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
From:		To:	
<input type="text"/>		<input type="text"/>	
Dates of Treatment (Fill in From/To above)			

Member's Application for Disability Retirement

Disability Type: Member: SSN: ***-**-_____

Physicians, Hospitals and Medical Facilities

Please list all physicians, hospitals and medical facilities with which you have consulted for your claimed disability. In addition, please list any physicians, hospitals and medical facilities at which you have received any treatment for any other condition within the last five years.

Begin with your Emergency Room/Facility treatment regarding the injury claimed as the basis of your disability, followed by the most recent hospital or medical facility from which you sought a consultation or treatment.

If you need more space, you may attach additional sheets.

Name of Emergency Room/Facility			
Facility Street Address		City	State
Phone #		Fax #	Email
		From:	To:
Reason for Visit		Dates of Treatment (Fill in From/To above)	
Name of Physician or Facility			
Facility Street Address		City	State
Phone #		Fax #	Email
		From:	To:
Reason for Visit		Dates of Treatment (Fill in From/To above)	
Name of Physician or Facility			
Facility Street Address		City	State
Phone #		Fax #	Email
		From:	To:
Reason for Visit		Dates of Treatment (Fill in From/To above)	
Name of Physician or Facility			
Facility Street Address		City	State
Phone #		Fax #	Email
		From:	To:
Reason for Visit		Dates of Treatment (Fill in From/To above)	

Member's Application for Disability Retirement

Disability Type:
Member:
SSN: ***-**-____

Attorney Information

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

Name of Attorney		Name of Firm	
<input type="text"/>		<input type="text"/>	
Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Insurance Coverage

If you have any insurance that covers the incident(s) or hazard(s) that you have described, please provide the following information about each policy.

Name of Insurance Company		Policy # (if known)	
<input type="text"/>		<input type="text"/>	
Insurance Co. Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	Type of Coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of Insurance Company		Policy # (if known)	
<input type="text"/>		<input type="text"/>	
Insurance Co. Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	Type of Coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Disability Type: Member: SSN:

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The following authorization and selection forms are attached to your application. Make sure that you complete each of these forms and return them to your retirement board along with the rest of your completed application:

- Your signed *Authorization for Release of Medical and Insurance Records*
- Your signed *Regional Medical Panel Selection Form*

If your application is approved, you may need to submit additional documents, including, if applicable:

- Your marriage certificate
- Your spouse's birth certificate
- Your dependent children's birth certificates
- Your birth certificate
- Your military form DD214, if applicable

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Disability Type: **Member:** **SSN:** ***-**-_____

Authorization to Use or Disclose Protected Health Information

I hereby authorize:

(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

<input type="text"/>	<input type="text"/>
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Patient Name	Date of Birth
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Street Address	City	State	Zip Code
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Information To Be Disclosed To (Please check one): **PERAC**, 5 Middlesex Avenue, Suite 345, Somerville, MA 02145

Retirement Board (Enter address below)

Board Name:

Address:

City/Town: **State:** **Zip Code:**

Please check one below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

- Authorize Release of Complete Medical Record
- Authorize Release of Complete Medical Record with the following exceptions

Exceptions:

<input type="text"/>

This form encompasses the following:

- Disability Retirement Application: (Massachusetts General Laws, Chapter 32, Sections 6, 7, 26, 94, 94A and 94B)
- Restoration to Service Evaluation (including rehabilitation): (Massachusetts General Laws, Chapter 32, Sections 8 and 26)
- Accidental Death Benefit: (Massachusetts General Laws, Chapter 32, Sections 9 and 100)

I understand I may revoke this authorization at any time by notifying the Retirement Board or PERAC in writing, unless action has already been taken in reliance upon this authorization, or during an appeal under the applicable law.

This authorization will expire upon final determination of my disability application and Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process.

Signature of Patient or Legal Representative: **Date**

Printed Name of Patient or Patient's Rep.:

**Relationship to Patient/
Authority to Act for Patient, if applicable:**

Disability Type: Member: SSN:

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About the Authorization to Use or Disclose Protected Health Information

All entries must be completed for this authorization to be valid.

Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, Section 6, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, Sections 8 and 26, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CMEs), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process. The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.

Disability Type: Member: SSN:

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Medical Panel Selection

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. PERAC appoints all regional medical panels. When your retirement board determines that your application for disability retirement is complete, the board (which meets at least once each month) may petition PERAC to appoint a three-member state-financed independent regional medical panel to examine you.

No physician who has already examined you or treated you, except as part of a prior regional medical panel, can be appointed to a panel to examine you.

PERAC will schedule the regional medical panel examination(s) and notify you at least 14 days in advance of the date(s), time(s), and location(s).

Regional Medical Panel Selection Form**Three Separate Single Examinations or One Joint Examination**

- You have the right to request three separate single physician examinations when you file your disability application.
- If you do not request separate single examinations at application filing time a joint panel can be convened.
- You may request separate examinations at any time prior to a joint examination date, but PERAC will not ordinarily consider requests for separate examinations less than 48 hours prior to a scheduled joint examination.

You must indicate whether you prefer one joint examination or three separate single examinations by checking one of the boxes below:

I want to be examined by a joint regional medical panel.

I want to be scheduled for three separate single examinations.

By signing, I acknowledge that if I fail to appear at the scheduled medical appointment(s), I will be required to reimburse the Commonwealth for the cost of the examination, prior to the scheduling of a new examination.

Signature of Applicant: Date:

Member's Application for Disability Retirement

Disability Type:

Member:

SSN:

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Addendum Sheet to the Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.

Treating Physician's Statement Pertaining to a Member's Application for Disability Retirement

Updated March 2009

Who should complete this form?

In accordance with 840 CMR 10.06 (1) (b) (Code of Massachusetts Regulations), every member-applicant shall file a certificate from a licensed medical doctor.

Who will ask the physician to complete this form?

In the disability retirement application that an applicant submits to his/her retirement board, the applicant will identify the name, address, and phone number of the physician who has provided the care for his/her disability. The retirement board will send a copy of the *Physician's Statement* to the physician and request that the form be completed and returned to the retirement board.

Some applicants may choose to submit the *Physician's Statement* directly to their physician. Applicants should be sure to include the name, address, and phone number of their retirement board on the statement, if they take this course of action.

In order to avoid duplication of effort and confusion, if an applicant does submit the *Physician's Statement* directly to his/her physician, the applicant should be sure to inform his/her retirement board.

What is the process associated with this form?

A disability retirement application will not be considered complete until the completed *Physician's Statement* has been received by the applicant's retirement board. Delays in filing any of the required materials will impede timely processing of the application.

Are there terms particular to the legislative or legal process of disability retirement that the physician should consider when completing the *Physician's Statement*?

Yes, please review the last two pages of the *Physician's Statement*. Definitions are included there for: Accidental Disability; Aggravation of a Pre-Existing Condition; Ordinary Disability; Permanency Standard; Presumptions: Heart Law, Lung Law, and Cancer; and Risk of Re-injury.

Who should a primary treating physician contact if she or he has questions about this form?

If a primary treating physician needs further explanation about this form or the disability process in general, the physician should contact the applicant's retirement board.



Treating Physician's Statement Pertaining to a Member's Application for Disability Retirement

Updated March 2009

Retirement Board: Please place your address and phone number here. ▶

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Applicant's Last Name	First	M.I.	Name of Applicant's Retirement Board
<input type="text"/>			<input type="text" value="xxx-xx-"/>
Street Address of Applicant's Retirement Board			Applicant's Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip	Retirement Board Phone #

Type of Claimed Disability (please check one)

Accidental Ordinary Both Accidental and Ordinary

Note to Physician

As a physician who has been treating the above named applicant for his or her claimed disability, the retirement board will consider your analysis of the applicant's medical condition. Attention to this document will help you translate medical findings and opinions into language consistent with Massachusetts law, which in turn will help your patient with the process.

The Questions

You are asked to answer yes or no to questions (1) and (2) if the applicant is filing for an ordinary disability; yes or no to questions (1), (2), and (3A) if the applicant is filing for accidental disability without a presumption; and yes or no to questions (1), (2), and (3B) if the applicant is filing for accidental disability under a presumption.

Applications for Accidental Disability under a Presumption

The treating physician(s) submitting this form for a member who is applying for accidental disability benefits under a presumption should note that certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. The treating physician should be aware that a higher level of certainty (higher than what a doctor typically refers to, i.e., reasonable degree of medical certainty) will be required to overcome or rebut a presumption. Hence, overcoming a presumption is uncommon and requires a uniquely predominate non-work related influence.

The presumptions are cited in G.L. c. 32, §§94, 94A, 94B; they are the Heart, Lung, and Cancer Presumptions. Please review the definitions for these presumptions on Page 5 and 6 before completing this form.

Manner of Submission

You may either complete the narrative section of this report by handwriting your responses or submitting a narrative utilizing the items listed as your template. Your office notes and test results may be attached to further substantiate your conclusions.



Applicant's Last Name

First

M.I.

Social Security Number

(1.) Is the applicant mentally or physically incapable of performing the essential duties of his or her particular job? YES NO

Applicant's Date(s) of injury(s) or exposure(s):

Applicant's Job Title:

Job duties were reviewed? Yes No

Applicant able to perform essential duties? Yes No

If no, when was the applicant last able to perform essential duties?

Which essential duties cannot be performed by the applicant (restrictions)?

(2.) Is the condition for which the applicant seeks disability retirement likely to be permanent?

YES NO (Please refer to the attached Permanency Standard.)

What are the applicant's medical diagnoses?:

Please list key tests or imaging or other data confirming diagnoses:

Has the condition(s) changed over-time?

In the past 3 months? Yes No (If yes, please describe how.)

In the past year? Yes No (If yes, please describe how.)

Non-surgical therapeutic interventions and outcomes:

Medications:

PT:

Chiropractic:

Other:

			xxx-xx-
Applicant's Last Name	First	M.I.	Social Security Number

Surgical interventions and outcomes:

Type of Surgery	Date (mm/dd/yyyy)	Outcome

Your assessment of anticipated natural course of the diagnoses?

Stable or plateau
 Likely to regress
 Likely to resolve

Has Maximum Medical Improvement (MMI) been reached?
 Yes
 No

If you think the applicant's disability will continue indefinitely, please state why:

Complete (3A) if the member is filing an application for accidental disability without a presumption. If the member is filing under a presumption, only complete (3B) below.

(3A) Is said incapacity such as might be the natural and proximate result of the claimed personal injury sustained or hazard undergone in the performance of the applicant's duties and on account of which this disability retirement is based? YES NO

Describe the event(s) or onset of condition(s) that in your opinion led to applicant's disability:

What other life event/circumstance/condition in the applicant's medical history may have contributed to or resulted in the disability claimed?

Upon weighing the medical influence described, is it more likely that the disability was caused by the job-related personal injury or hazard undergone, or the non-work related event or circumstance or condition?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="xxx-xx-"/>
Applicant's Last Name	First	M.I.	Social Security Number

Complete (3B) if the member is filing an application for accidental disability under a presumption.

A presumption can be rebutted only by documentation of a uniquely predominant influence that shows the disability is not job-related.

(3B) For this particular applicant, is there no evidence of a uniquely predominant non-service connected influence on his/her mental or physical condition and/or a non-service connected accident or hazard which caused his/her incapacity? If there is no evidence of such influence, then you must answer yes. If there is evidence of such influence, you must answer no. YES NO

If you answer No to (3B), please explain the uniquely predominant influence which brings you to this conclusion.

I, the undersigned physician, understand that has applied for disability retirement pursuant to the provisions of Massachusetts General Laws, Chapter 32. I have conducted a physical examination and have knowledge of the pertinent facts of his/her case as described. I certify that I have read and understand the information contained in this statement, and subscribe, under the penalties of perjury, that the information I have supplied in this statement and in my medical reports (if applicable) is true, complete, and correct to the best of my knowledge.

I am certified to practice medicine in (state(s))

My Medical License Number is Date Issued (mm/dd/yyyy)

My license was issued by (state)

Physician's Name (print)

Physician's Signature _____ Date _____

Physician's Medical Specialty

Physician's Street Address

<input type="text"/>	<input type="text"/>	<input type="text"/>
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City State Zip

Physician's Phone Number Physician's Fax Number

Definition of Terms

Accidental Disability

In an application for Accidental Disability Retirement, an applicant asserts that his or her disability is the result of a job-related incident or injury. For such applications, your responses to Questions 1, 2, and 3 are required.

Aggravation of a Pre-Existing Condition

You may find that a previous condition or injury is related to the condition or injury that is the basis of the disability application. If the acceleration of a pre-existing condition or injury is as a result of an accident or hazard undergone, in performance of the applicant's duties, causation would be established. However, if the disability is due to the natural progression of the pre-existing condition or was not aggravated by the alleged injury sustained or hazard undergone, causation would not be established.

Ordinary Disability

In an application for Ordinary Disability Retirement, an applicant does not assert that his or her disability is the result of a job-related incident or injury. For such applications, your response to Question 3 is not necessary. But please note that you may also respond to Question 3, if your determination is that consideration of causality is appropriate even though the applicant has not applied for accidental disability retirement.

Permanency Standard

A disability is permanent if it will continue for an indefinite period of time that is likely to never end even though recovery at some remote, unknown time is possible. If you are unable to determine when the applicant will no longer be disabled, you must consider the disability to be permanent. However, if the recovery is reasonably certain after a fairly definite time, the disability cannot be classified as permanent. It is imperative that the physician makes his/her determination based on the actual examination of the applicant and other available medical tests or medical records that have been provided. It is not the physician's task to look into employment possibilities that may become available to an applicant at some future point in time.

Presumptions

Certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. Additional information about these presumptions is available from the Public Employee Retirement Administration Commission. The presumptions are:

Heart Law (G.L. c. 32, § 94)

A disability or death caused by heart disease or hypertension is presumed to be suffered in the line of duty for public safety positions, including certain fire fighters, police officers, corrections officers, and public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

Lung Law (G.L. c. 32, § 94A)

A disability or death caused by diseases of the lungs or respiratory tract is presumed to be suffered in the line of duty as a result of inhalation of noxious fumes or poisonous gas for certain fire fighters or public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

Cancer Presumption (G.L. c. 32, § 94B)

A disability or death caused by certain cancers is presumed to be suffered in the line of duty as a result of exposure to heat, radiant, or a known or suspected carcinogen for certain fire fighters or public safety employees at the international airport. The employee (or retiree) must have been employed in an eligible position on or after July 5, 1990, must have served in such a position for five years or more at the time such condition is or should have been discovered, must have regularly responded to fires during some portion of his/her service, and must discover such cancer within five years of the last date of his/her active service. A retired firefighter or a public safety employee at the international airport where such condition is or should have been discovered within five years of retirement may be eligible for this presumption. The presumption can be rebutted by a preponderance of the evidence that shows that the disability was caused by non-service-related risk factors or accidents or hazards undergone.

Risk of Re-injury

The Contributory Retirement Appeal Board (CRAB) has found, "even if a member is physically capable of performing all of the essential duties of his or her position, he or she may be disqualified if a return to work would pose an unreasonable risk to serious harm to the member or third parties." This risk of re-injury has to reasonably be expected to involve a substantial harm.

**Addendum Sheet
to the
Treating Physician's Statement**

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.