Introduction
Member’s Application for Disability Retirement
Updated August, 2008

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. 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, personally convey the Physician's Statement to your primary treating physician. If you choose to do so, let your retirement board know so that confusion and 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.
Introduction
Member's Application for Disability Retirement

Timeframes
- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.

- You will be given 14 days notice of the scheduled examination.

- 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 report, PERAC will forward the report to your retirement board.

- 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.

- 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.

- 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 30 days 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.
Member’s Application for Disability Retirement
Updated August, 2008 | Previously Identified as PERA 10-1, 10-3, 10-4, 10-5, 10-6 (1-3), 10-19A-792

Intent to Retire

Applicant’s Last Name ___________________________ First ___________________________ M.I. ___________________________ Former or Maiden Name (If different) ___________________________

Street Address ___________________________

City ___________________________ State ___________________________ Zip ___________________________ Phone # ___________________________

Social Security # xxx-xx-

Date of Birth ___________________________ Place of Birth ___________________________

Sex M □ F □ Yes □ No □ Are you a veteran?

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 ___________________________

Phone # ___________________________

City ___________________________ State ___________________________ Zip ___________________________

From ___________________________ To ___________________________

Dates in Residence at Your Alt. Address

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 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 based on this application, if that is my preference and I meet the other requirements for Ordinary Disability benefits.

I apply to be retired on the basis of (Please check one):

□ Accidental Disability □ Ordinary Disability □ Either Accidental or Ordinary Disability

I sign this application under the pains and 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 ___________________________

COMMONWEALTH OF MASSACHUSETTS | PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
WEB | WWW.MASS.GOV/PERAC
Member's Application for Disability Retirement

Applicant's Last Name  

First  

M.I.  

Social Security #  

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 reason for which you are filing this application for disability retirement.

(2) Please describe the duties that you are required to perform in your current position.

(3) How frequently are you required to perform these duties?

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

(5) When did you cease to be able to perform all of the essential duties of your position?
**Member's Application for Disability Retirement**

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<th>Applicant's Last Name</th>
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**Your Employment History**

**Your Current Position** (From which you plan to retire)

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<th>Name of Direct Supervisor</th>
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**All of Your Previous Positions**

Please list all previous employment in chronological order, beginning with your first 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.

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Member’s Application for Disability Retirement

Applicant’s Last Name
First M.I. Social Security #

Statements About Your Background, Qualifications & Recent Physical Activities

(1) Are you a high school graduate? ☐ Yes ☐ No
If you completed some but not all of high school, please indicate the last grade that you did complete.

(2) Are you a college graduate? ☐ Yes ☐ No
If you completed some but not all of college, please indicate the last year that you did complete.

(3) Special qualifications, certifications or licenses that you hold:

(4) For the period of the last year, please describe your physical activities, including:
(A) Medical rehabilitation activities

(B) Activities of daily living (for example, driving, cleaning, etc.)

(C) Sports or other strenuous activities

(D) Other employment since the onset of your disability
G.L. c. 32, § 15
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 applying for ordinary disability, you are not required to complete the rest of page 5 & 6-8. But, if you feel that responses in this section are relevant, you may offer them.

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).

Please identify the reason for your disability:  □ Personal Injury  □ Hazard
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.

(1) Date(s)

(2) Specific time(s) or if hazard, length of time exposed

(3) Location(s)

(4) Description of incident(s) or hazard
### Member's Application for Disability Retirement

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(5) Please describe the job duties you were performing just prior to and at the time you sustained your personal injury or were exposed to the hazard.

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<tr>
<th>Incident Reports</th>
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<tbody>
<tr>
<td>Please provide the following information about each person or agency with which you filed a report of the incident(s) that you sustained or the hazard to which you were exposed.</td>
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<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>Agency</th>
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<tr>
<td>Street Address</td>
<td>City</td>
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<tr>
<td>Phone #</td>
<td>Date You Filed Report</td>
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<td>City</td>
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<td>Phone #</td>
<td>Date You Filed Report</td>
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### Witness Data

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

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<tr>
<th>Name (Last, First, Middle Initial)</th>
<th>Phone #</th>
<th>Relationship To You</th>
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Other Actions Taken
As a result of the incidents or hazards that you have described, have you filed a grievance pursuant to a collective bargaining agreement?

☐ Not applicable  ☐ No  ☐ Yes

If “yes”, please describe the status of your grievance.

______________________________

Did your employer take any administrative or disciplinary action as a result of the incidents or hazards you have described?

______________________________

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?

______________________________

Section 111F Benefits
Have you received or are you receiving benefits, related to your claimed disability, pursuant to G.L. c. 41, § 111F?

______________________________
Emergency Medical Treatment
If you received emergency medical treatment as a result of the incident(s) or hazard(s) you've described, please provide the following information about each health care provider who furnished such treatment to you.

Health Care Provider’s Name

Hospital/Facility

Street Address

City

From

State

To

Zip

Phone #

Date(s) of Treatment
Hospitals and Medical Facilities
Please list all hospitals and medical facilities with which you have consulted or at which you have received any treatment for any condition within the last five years. Begin with the hospital or medical facility from which you first sought a consultation or treatment. If you need more space, you may attach additional sheets.

Name of Facility ____________________________ Reason for Visit ____________________________
Street Address ____________________________ City ____________________________ State Zip
From _______ To _______
Phone # ____________________________ Date(s) of Treatment ____________________________

Name of Facility ____________________________ Reason for Visit ____________________________
Street Address ____________________________ City ____________________________ State Zip
From _______ To _______
Phone # ____________________________ Date(s) of Treatment ____________________________

Name of Facility ____________________________ Reason for Visit ____________________________
Street Address ____________________________ City ____________________________ State Zip
From _______ To _______
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### Member's Application for Disability Retirement

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#### Physicians

Please list all physicians with whom you have consulted or from whom you have received any treatment for any condition within the last five years. Begin with the physician you consulted first. If you need more space, you may attach additional sheets.

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<tr>
<th>Name of Physician</th>
<th>Reason for Visit</th>
<th>Street Address</th>
<th>City</th>
<th>State</th>
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<th>From</th>
<th>To</th>
<th>Date(s) of Treatment</th>
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Member's Application for Disability Retirement

Applicant's Last Name
First
M.I.
Social Security #

Primary 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 primary treatment in connection with your disability.

Name of Primary Treating Physician

Street Address

City
State
Zip

Phone #

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

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

Street Address

City
State
Zip

Phone #
### Insurance Coverage

If you have any insurance that covers the incidents or hazards that you have described, please provide the following information about each policy.

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Member's Application for Disability Retirement

Retirement Board Authorization to Use or Disclose Protected Health Information

1. I hereby authorize: [blank]
(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.

2. Patient Name: [blank] Date of Birth: [blank]

Street Address [blank] City [blank] State [blank] Zip [blank]

3. Information to be disclosed to: [blank] Retirement Board
Enter Address:

Street Address [blank] City [blank] State [blank] Zip [blank]

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

☐ Authorize Release of Complete Medical Record

Exceptions:

5. I have checked the box below indicating the purpose for the disclosure of this information.

☐ Disability Retirement Application: (G.L. c.32, §6 & §7)

☐ Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)

☐ Accidental Death Benefit: (G.L. c.32, §9 & §100)

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

7. This authorization will expire upon final determination of my disability application or Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed below.

8. ____________________________ 10. __________
Signature of Patient or Legal Representative Date

9. ____________________________ Relationship to Patient/Authority
Printed Name of Patient or Patient's Representative to Act for Patient if Applicable
Retirement Board Authorization to Use or Disclose Protected Health Information (Continued)

All numbered 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, sections 6 and 7, 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, section 8, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CME), 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.
Applicant’s Authorization for Release of Tax Records

This will certify that I authorize release of information from the federal Internal Revenue Service and the Massachusetts Department of Revenue relative to my annual gross earned income pursuant to any agreement between the federal Internal Revenue Service, the Massachusetts Department of Revenue and the Public Employee Retirement Administration Commission.

I understand that G.L. c. 32, § 6 and 7 require this authorization and my failure to provide this release may result in the denial, suspension and/or termination of my benefits.

Signature of Applicant

Name of Applicant (Please Print)

Social Security #
Regional Medical Panel Selection Form

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. The Public Employee Retirement Administration Commission (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).

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. Such separate examinations can be scheduled by PERAC to take place on three separate days in three separate locations.

- If you do not request separate single examinations at application filing time, PERAC will generally schedule a joint examination. In instances where a joint examination cannot be convened in a timely fashion, PERAC may schedule separate single examinations instead.

- 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.
The following authorization and selection forms are included in 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 Authorization for Release of Tax Records
- Your signed Regional Medical Panel Selection Form

Copies of the following documents should be attached to your Application:

- Your birth certificate
- Your military form DD214, if applicable to your personal situation
- Copies of incident reports that you filed, if applicable to your personal situation

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
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.
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**

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<th>Retirement Board: Please place your address and phone number here.</th>
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<th>M.I.</th>
<th>Name of Applicant’s Retirement Board</th>
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**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.
Treating Physician's Statement, Disability Retirement Application

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: __________________________________________________________________________
### Treating Physician’s Statement, Disability Retirement Application

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<th>Applicant’s Last Name</th>
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<th>M.I.</th>
<th>Social Security Number</th>
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**Surgical interventions and outcomes:**

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<th>Type of Surgery</th>
<th>Date</th>
<th>Outcome</th>
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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?

---
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 ______________

My license was issued by __________________________ (state)

Physician’s Name (print) __________________________

Physician’s Signature __________________________ Date ______________

Physician’s Medical Specialty __________________________

Physician’s Street Address __________________________

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 reinjury has to reasonably be expected to involve a substantial harm.
Introduction
Choice of Retirement Option Form at Retirement
Form Last Revised: March, 2002

The Choice of Retirement Option Form at Retirement allows a member who has applied for retirement to select whether to receive their entire retirement allowance during their lifetime or to leave a lump sum or allowance for their survivor(s). Descriptions and the amounts of a retirement allowance paid pursuant to Options A, B and C are included on the form. Keep in mind:

- You may only select one Option.

- Please consult with your retirement board to be certain that you understand the effect of selecting an Option. Your retirement board can provide you with a personalized estimate of each benefit.

- If you are married, the Spousal Acknowledgement on this form must be signed by your spouse.

- A witness must sign page three of this form.
Choice of Retirement Option Form at Retirement

Form Last Revised: March, 2002

Middlesex County Retirement System
25 Linnell Circle
PO Box 160
Billerica, MA 01865

Member's Information

Member's Last Name (Print)  [ ]  First  [ ]  M.I.  [ ]  Date

Instructions
When you apply for retirement, you may select one of three retirement allowance payment Options (A, B or C). For the Option selection to be valid, this completed form must be filed with your retirement board:

- on or before the date the board receives your written application for retirement, or
- on or before the date your allowance becomes effective, or
- not more than 15 days after the board receives a written application for your involuntary retirement from your department head.

1. You may change your Option selection before your retirement becomes effective by filing a new form.

2. You may not change your Option selection once your retirement becomes effective.

3. If no Option selection is made or none is in effect, your allowance will be paid under Option (B).

4. The spousal acknowledgement at the end of this form must be signed if you are married.

Selection of Retirement Option
After reviewing all retirement Options, please sign your name under only one of the Options.

Option (A) No Payment to Beneficiary
Your retirement allowance will be approximately $________ annually for life and all payments will cease upon your death. This Option provides for a full retirement allowance payable in monthly installments during your lifetime. All allowance payments will cease upon your death and no benefits will be provided for any survivors.

To the Retirement Board
I choose to have my retirement allowance paid in accordance with the provisions of G.L. c. 32, § 12(2)(a) of the General Laws which provides an allowance as explained above. I understand that this Option provides the largest possible payment to me under the retirement law and that all payments thereunder cease at my death. I also understand that by choosing this Option, I relinquish on the date that my retirement takes effect all claim to my total accumulated deductions with interest and that upon my death my beneficiary (or estate) will have no claim on these monies.

Member's Signature  ______________________  Date  ______________

Member's Social Security #  ______________________
Option (B) Lump Sum Payment to Beneficiary

Your retirement allowance will be approximately $_____ annually for life. The payments under this Option are smaller than under Option (A). The annuity portion of your allowance is reduced to allow a lump sum benefit for your named beneficiary(ies). Upon your death, your named beneficiary(ies), or if there is no beneficiary living, the person or persons appearing in the judgment of the retirement board to be entitled thereto will be paid the unexpended balance of your annuity account. Please note that the contributions comprising the annuity account will be depleted within approximately twelve to fifteen years depending upon your age at retirement. The longer you live, the less will be paid to your beneficiary(ies) upon your death. If your account has been fully depleted, nothing will be paid. You may designate and change at any time, one or more beneficiaries to receive in designated proportions, or in the alternative, the lump sum Option (B) benefit. This Option takes effect upon your retirement and supercedes any prior beneficiary selections.

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To the Retirement Board
I choose to have my retirement allowance paid in accordance with the provisions of G.L. c 32, § 12(2)(b) which provides a cash refund annuity as explained above. I understand that this Option provides for a smaller retirement allowance for life but that if I die before the amount which I have received in annuity payments equals the sum of my total deductions with interest to the date of my retirement, the difference will be paid to my designated beneficiary(ies).

Member’s Signature ___________________ Date ____________
Member’s Social Security # ____________

Option (C) Payment of Allowance to Beneficiary

Your retirement allowance will be approximately $_____ annually for life. Election of Option (C) provides for a monthly retirement allowance during your lifetime that is less than you would receive under either Option (A) or Option (B). Upon your death your designated beneficiary will be paid a monthly allowance for the remainder of his or her lifetime. That allowance will be equal to two-thirds of the allowance that you were receiving at the time of your death. The monthly allowance you receive under Option (C) is based upon life expectancy factors for you and your designated beneficiary. Only your spouse, former spouse who has not remarried, mother, father, sister, brother or child may be designated as your Option (C) beneficiary. The younger your beneficiary, the lesser the amount of your retirement allowance. If, after you retire, your Option (C) beneficiary predeceases you, you will thereafter be paid the full retirement allowance you would have received had you elected Option (A) at the time your retirement allowance became effective. This conversion is commonly referred to as the Option (C) “pop-up”. Please note that after the Option (C) “pop-up” takes place you may not name another Option (C) beneficiary or choose another Option.
Choice of Retirement Option Form at Retirement

Member's Last Name  [Name]
First  [Name]
M.I.  [Name]
Social Security #  [Number]

To the Retirement Board: I choose to have my retirement allowance paid in accordance with the provisions of G.L. c. 32, § 12(2)(c) which provides an allowance as explained above. I understand that this retirement allowance will be smaller than under Option (A) or Option (B) but that upon my death two-thirds of this allowance will be paid to the named beneficiary for said beneficiary's life.

Beneficiary's Name  [Name]
Date of Birth  [Date]
Relation to Member  [Relation]
Social Security #  [Number]
Member's Signature  [Signature]
Date  [Date]
Member's Social Security #  [Number]

Witness
To the Retirement Board: I have read this form with the member whose selection of an Option is made on this document and at his or her request have witnessed his or her signature thereto.

Witness' Signature  [Signature]
Date  [Date]
Witness' Name (Print)  [Name]

Spousal Acknowledgment
For any member who is married, an election shall not be valid unless it is accompanied by the signature of the member’s spouse indicating the member’s spouse’s knowledge and understanding of the retirement Option selected. The retirement board shall provide the member and spouse with detailed information regarding the benefit Option selected in order for the member and spouse to make an informed decision regarding said Option. If any member who is married files an election which is not so accompanied, the board shall within fifteen days notify the member’s spouse by registered mail of the Option election and of the spouse’s right to sign and return an acknowledgment of receipt and understanding of such information within thirty days after receipt of the acknowledgment. The election shall not take effect until it is accompanied by the signature of the member’s spouse; provided, however, that no such signature shall be required if the spouse fails to submit such signed acknowledgment on or before the thirtieth day from receipt of the information from the retirement board. Such election made prior to the spousal notification may be changed in accordance with the spouse’s understanding of the retirement allowance selected, or at any later time otherwise permitted under this chapter.

IMPORTANT: If you are the spouse of a member, please be certain you have read and understand the foregoing provision relating to your spouse’s Option selection. If you do not understand any part of the Option selected by your spouse, please ask for an explanation from your spouse’s retirement board. Your signature is not consent or approval, only an acknowledgement of the Option chosen by your spouse.

- Do not sign below unless you understand the Option selected by your spouse and the benefits to which you may or may not be entitled to at his/her death.

Spouse's Signature  [Signature]
Date  [Date]
Spouse's Name (Print)  [Name]
AFFIDAVIT OF MEMBER AS TO MARITAL STATUS UPON RETIREMENT OR APPLICATION FOR RETURN OF ACCUMULATED DEDUCTIONS

I, the undersigned member of the Middlesex County Retirement System, under oath, hereby affirm and attest as follows: [Initial all that apply.]

___ I am not married.

___ I am presently married to ____________________________________________________. A Marriage Certificate has been provided to the Middlesex County Retirement System.

___ My spouse has witnessed the Option Selection Form and has knowledge and understanding of the retirement option I have selected.

___ My spouse has not witnessed the Option Selection Form.

I was formerly married to ____________________________ and became divorced on ___________________________ at ___________________________.
The Judgment of Divorce, Settlement Agreement and/or Domestic Relations Order (does ___ ) (does not___ ) obligate the Middlesex County Retirement System to pay benefits to my former spouse or to children of this marriage.

I agree to file with the Middlesex County Retirement System an attested copy of the Judgment of Divorce, Divorce Agreement and/or Domestic Relations Order, prior to the effective date of my retirement or return of my accumulated deductions.

[If divorced more than once, please provide information for all divorces.]

I understand that my failure to provide truthful information regarding my marital status and the existence of court ordered payments upon my retirement or return of my accumulated retirement deductions may result in criminal and civil liability.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY

MEMBER'S SIGNATURE  DATE

WITNESS SIGNATURE  DATE
Introduction
Employer's Statement Pertaining to a Member's Application for Disability Retirement
Updated August, 2003

Who should prepare this form?
In accordance with 840 CMR 10.07 (Code of Massachusetts Regulations), the Employer's Statement should be prepared by the head of the department that employs the disability retiree applicant. However, if the department head does not supervise the applicant, the applicant's direct supervisor should prepare and sign this statement and it should be counter-signed by the department head.

What is the timeframe associated with this form?
The Employer's Statement should be completed and filed with the applicant's retirement board within fifteen days of its being received by the employer.

Who will ask the employer to complete this form?
In the retirement application that an applicant submits to his/her retirement board, the applicant will identify the name and address of his/her department head and his/her direct supervisor. The retirement board will send a copy of the Employer's Statement to the applicant's department head and request that the form be completed.

If an employer has questions about this form, who should be contacted?
If an employer needs further explanation about this form or the disability process in general, the employer should contact the member's retirement board.

What documents must the employer attach to the Employer's Statement?
- A copy of the applicant's current official job description. In that job description, the employer must designate those duties that are essential. Employers should use the "Determination of Essential Duties" section of the Employer's Statement as a guideline.
- Copies of any and all records regarding the applicant's physical condition at the time of his or her employment with the department (for example, a pre-employment physical examination).
- Copies of any and all records regarding the applicant's physical condition after he or she was employed by the department.
- Copies of any and all records pertaining to the applicant's education, training, qualifications, or certification (for example, a resume or job application).
- Copies of all reports or investigations concerning the applicant's incidents or hazards.
- Copies of any and all Workers' Compensation incident reports and/or any Workers' Compensation settlement agreements made on behalf of the applicant.
- Copies of any and all reports associated with the applicant's G.L. c. 41, § 111F benefits.
Employer’s Statement Pertaining to a Member’s Application for Disability Retirement

Updated August, 2003

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

Middlesex County Retirement System
25 Linell Circle
PO Box 160
Billerica, MA 01865

Applicant’s Last Name ______________ First ______________ M.I. ______________ Social Security # ______________

Name of Retirement Board ______________ Street Address of Retirement Board ______________

Retirement Board Phone # ______________ City ______________ State ______________ Zip ______________

Basis of Disability (Please describe) _______________________________________________________________________

Type of Disability (Please check one):

☐ Accidental ☐ Ordinary ☐ Both Accidental and Ordinary

Name of Direct Supervisor ______________ Title ______________

Street Address ______________ Name of Department/Agency ______________

City ______________ State ______________ Zip ______________ Phone ______________ Fax ______________

Name of Department Head ______________ Title ______________

Street Address ______________ Name of Department/Agency ______________

City ______________ State ______________ Zip ______________ Phone ______________ Fax ______________
Employer’s Statement Pertaining to Member’s Application for Disability Retirement

Applicant’s Last Name

First

M.I.

Social Security #

Applicant’s Current Employment

Applicant’s Functional Title

Date Employment Began

Date Employment Ended

Position Classified Under Civil Service

Yes

No

Last Date Able To Perform Essential Duties

(1) Please describe the essential duties that the applicant is required to perform in his or her current position. (Please see the last page of this document for a definition of essential duties.)


(2) How frequently is the applicant required to perform these essential duties?


(3) Please describe the physical requirements of the applicant’s current position. (For example, how much lifting, bending, strength, etc. is necessary.)


(4) Of the physical requirements described above, are there any that the applicant cannot perform because of the claimed disability?


(5) Could the applicant perform the essential duties of his or her current position if he or she was reasonably accommodated?


(6) Based on the applicant’s experience and qualifications, are there any positions that the applicant could hold now or in the future?
Employer’s Statement Pertaining to Member’s Application for Disability Retirement

Applicant’s Last Name ___________________________  First ___________________________  M.I. ___________________________  Social Security # ___________________________

(7) Has this employee been officially investigated for or charged with misappropriation of funds from his/her employer or convicted of any crime related to his/her office or position? □ Yes  □ No
If yes, please provide documentation.

Medical Condition & Current Employment

(1) Has the applicant’s medical condition affected his or her attendance and job performance? Please describe how.


(2) Did the applicant request any modification of job duties in order to accommodate his or her medical condition? If yes, please explain.


(3) Has your department offered any modification of job duties or other reasonable accommodations to the applicant because of his or her medical condition? If so, please explain.


(4) Did the applicant file any grievances against your department that could be related to his or her claim for disability? Please explain the status of any such grievance.


(5) Based on the applicant’s claim of disability, has your department conducted any tests or studies on the building in which your department is located or the surrounding grounds? If yes, please explain.


(6) Is the applicant’s claimed disability the result of or in any way related to, a personnel action? If yes, please explain.
Employer's Statement Pertaining to Member's Application for Disability Retirement

Applicant's Last Name  First  M.I.  Social Security #

(7) Is the applicant's claimed disability the result of any misconduct on his/her part? If yes, please explain.

Circumstances Related to Claim of Accidental Disability

If you are aware of any incidents or hazards that are related to the applicant's job duties that may have caused or contributed to the applicant's claimed disability, provide information about them, in as specific a manner as possible, in the following section. If the space provided proves to be insufficient, you may attach additional sheets to this document. If you are not aware of any such job related incidents or hazards, skip this section.

One of the conditions for receiving approval of an application for accidental disability retirement benefits is that the retirement board must find that the applicant's disability is the natural and proximate result of either:

- A personal injury sustained (usually, one or several specific incidents) or
- A hazard undergone (generally, exposure to a harmful situation over a period of time).

Occurrence #1 of an Incident or Hazard Related to the Applicant's Job Duties

Date  Time  Location

Description of Incident or Hazard

Witness Data Related to Occurrence #1 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the incident or hazard (related to the applicant's job duties) described above.

Name

Street Address  Relationship to Applicant

City  State  Zip  Phone #
Occurrence #2 of an Incident or Hazard Related to the Applicant's Job Duties

Date [ ] Time [ ] Location

Description of Incident or Hazard

Witness Data Related to Occurrence #2 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the incident or hazard (related to the applicant's job duties) described above.

Name

Street Address [ ] Relationship to Applicant

City [ ] State [ ] Zip [ ] Phone #
Are you are aware of any incidents or hazards that are not related to the applicant’s job duties that may have caused or contributed to the applicant’s claimed disability? If so, provide information about them in the following section. If you are not aware of any such non-job related incidents or hazards, skip this section.

Occurrence of an Incident or Hazard NOT Related to the Applicant’s Job Duties

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<th>Time</th>
<th>Location</th>
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Description of Incident or Hazard

Witness Data Related to Occurrence of an Incident or Hazard NOT Related to the Applicant’s Job Duties:
Please provide the following information about each individual who witnessed the incident or hazard (not related to the applicant’s job duties) described above.

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<th>Relationship to Applicant</th>
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Early Intervention Plan

(1) Has the applicant been offered an early intervention plan pursuant to G.L. c. 32, § 5B?

[ ] Yes  [ ] No

(2) Has the applicant failed to participate in the assessment or required rehabilitation of an early intervention plan pursuant to G.L. c. 32, § 5B?

[ ] Yes  [ ] No
Workers' Compensation (Related to the Applicant's Claimed Disability)

(1) Has the applicant applied for Workers' Compensation benefits?

☐ Yes  ☐ No

If yes, please provide the date of application: __________

(2) Has the applicant received or is he/she now receiving Workers' Compensation benefits?

☐ Yes  ☐ No

If yes, please provide the following information:

(A) Date weekly payments commenced: __________

(B) Amount of weekly payment: __________

(C) Date payments terminated, if relevant: __________

(D) Did the Treasurer/DIA construct a rehabilitation plan in the course of the applicant's Workers' Compensation claim?

☐ Yes  ☐ No

(3) Has the applicant received a Workers' Compensation settlement?

☐ Yes  ☐ No

If yes, record the date the settlement was awarded: __________

Section IIII F Benefits (Related to the Applicant’s Claimed Disability)

(1) Has the applicant received or is he or she receiving benefits pursuant to G.L. c. 41, § IIIIF?

☐ Yes  ☐ No

If yes, please provide dates for the periods during which § IIIIF benefits are or were being paid:
Employer's Statement Pertaining to Member's Application for Disability Retirement

Applicant's Last Name
First
M.I.
Social Security #

Required Signatures

I, the undersigned, have been authorized by the department/agency listed on page 1 to prepare this statement. I understand that the above named applicant has applied for disability retirement pursuant to the provisions of Massachusetts General Laws Chapter 32. I certify that I have read and understand the information contained in this statement, and I subscribe, under the pains and penalties of perjury, that the information I have supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Direct Supervisor (Print):

Signature of Direct Supervisor
Date

I, the undersigned, have been authorized by the department/agency listed on page 1 to counter sign this statement. I understand that the above named applicant has applied for disability retirement pursuant to the provisions of Massachusetts General Laws Chapter 32. I certify that I have read and understand the information contained in this statement, and I subscribe, under the pains and penalties of perjury, that the information supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Department Head (Print):

Signature of Department Head
Date
Determination of Essential Duties

In connection with all applications for disability retirement and evaluations, a determination of the essential duties of the relevant job or position shall be made.

The determination of what constitutes an essential duty of a job or position is to be made by the employer, based on all relevant facts and circumstances and after consideration of a number of factors.

Please note that if the Commonwealth’s Human Resources Division has promulgated a list or description of essential duties for a position that is consistent with those of the member’s position, the employer shall submit such a list or description as the essential duties for the position in question.

The telephone number of the Commonwealth’s Human Resources Division is 617-727-3777. Their website address is http://www.magnet.state.ma.us/hrd/hrd.htm. It is anticipated that job specifications will be posted there.

The term “essential duties” as used in Massachusetts General Laws, Chapter 32 and in all regulations promulgated by the Public Employee Retirement Administration Commission shall mean those duties or functions of a job or position which must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. The essential duties of a position are those that bear more than a marginal relationship to the position. In making the determination as to whether a function or duty is essential, the employer shall consider and provide documentation to include, but not be limited to:

- The nature of the employer’s operation and the organizational structure of the employer;
- Current written job descriptions;
- Whether the employer requires all employees in a particular position to be prepared to perform a specific duty;
- The number of employees available, if any, among whom the performance of the job function can be distributed;
- The amount of time that employees spend performing the function;
- Whether the function is so highly specialized that the person in the position was hired for his or her special ability to perform the function;
- The consequences of not requiring the employee to perform the function;
- The actual experience of those persons who hold and have held the position or similar positions; and
- Collective bargaining agreements.
Addendum Sheet
to the
Employer's Statement Pertaining to 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.
NOTIFICATION OF RIGHTS OF THE
MIDDLESEX COUNTY RETIREMENT SYSTEM
UNDER GENERAL LAWS CHAPTER 32

TO: APPLICANTS FOR DISABILITY RETIREMENT BENEFITS
    APPLICANTS FOR ACCIDENTAL DEATH BENEFITS

I AM ADVISED:

That the Middlesex County Retirement System has the statutory obligation to offset from disability retirement or accidental death benefits all payments of workers' compensation under General Laws Chapter 152 resulting from the same injury or death.

That the failure to apply for workers' compensation may result in a suspension of retirement benefits; and further, the Middlesex County Retirement System may apply for workers' compensation benefits on my behalf.

That the Middlesex County Retirement System has the statutory obligation to offset from disability retirement or accidental death benefits the recovery of lost wages from a third party other than the employer resulting from the same injury or death.

That the failure to pursue a third party claim where appropriate may result in a suspension of retirement benefits; and further, the Middlesex County Retirement System may file a claim for lost wages on my behalf.

THEREFORE, I AGREE:

(1) To cooperate with the Middlesex County Retirement System with reference to the above, and to notify the Middlesex County Retirement System of any changes in my workers' compensation status;

(2) To notify the Middlesex County Retirement System of the filing of any claim against a third party for benefits or damages; and,

(3) To notify the Middlesex County Retirement System PRIOR to settlement of the workers' compensation and/or a third party claim resulting from the same injury or death.

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS NOTICE.

Date

Member's Signature
CONSENT TO RELEASE OF WORKERS' COMPENSATION INFORMATION
840 CMR 10.06(l)(g)(4)

Employee: ________________________________

Employer: ________________________________

Insurer: __________________________________

Date(s) of Injury: _________________________

I hereby consent, without restriction, to release of all worker's compensation information and records pertaining to the above claim, including, but not limited to:

Records of All Physicians or Medical Institutions; Records of All Physical Examinations Performed; Accident Reports, Claim and Investigation Reports; Agreements for Compensation; Department of Industrial Accidents Orders, Decisions or Approved Settlements.

I understand that this information may contain details of a highly personal or intimate nature, and that the information and records may be otherwise exempt from disclosure, except where authorized by law or regulation.

Date __________________ Signature __________________