FAIRFAX COUNTY DISABILITY RETIREMENT EXAMINATION REPORT

DATE:

TO: Board of Trustees
Uniformed Retirement System

FROM: Medical Examining Board

Retirement Systems Use Only:

Application for
( ) Ordinary Disability
( ) Service-Connected Disability
Agency: ______________________________
Applicant's Age: ________________________
Service: _______________________________
Estimated Monthly Annuity: _______________

Applicant:
( ) is eligible for Workers' Compensation
( ) has applied for Workers' Compensation
( ) is receiving Workers' Compensation

Applicant's Name:

Occupation:

Date of Examination:

Diagnosis (Primary):

Other (Secondary) illness, disease, or infirmity:

Physical limitations as a result of illness:

Review of medical reports submitted:

Result of examination:

FOR ORDINARY DISABILITY RETIREMENT APPLICATIONS:
(Block out what does not apply)

I hereby certify that as a result of the illness(es) described above, the individual named above (is) (is not) physically or mentally incapacitated from performing his or her job duties, and this condition is likely to be permanent.

Date: Physician's signature:

FOR SERVICE-CONNECTED DISABILITY RETIREMENT APPLICATIONS:
(Block out what does not apply)

Review of the accompanying medical evidence and supporting documents consisting of ___ pages indicates that the above condition (is) (is not) due to injury by accident and/or disease which arose out of and in the course of applicant's service.

Date: Physician's signature:

FOR HEART-LUNG DISABILITY CASES ONLY

In cases of applications for disability retirement by deputy sheriffs on account of hypertension or heart disease or by firefighters on account of hypertension, heart disease, or respiratory disease, the certifying physician must make the following findings:

A. *Causation (Make the appropriate finding ? Block out what does not apply)*

1. Review of the accompanying medical evidence and supporting documents consisting of _____ pages indicates that the indicated (respiratory disease) (hypertension) (heart disease) is the result of the following specific non-work related cause(s):

Date:_______________ Physician's signature ____

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2. Based on review of the accompanying medical evidence and supporting documents consisting of _____ pages, it is not possible to identify a specific probable non-work related cause for the indicated (respiratory disease) (hypertension) (heart disease).

Date:_______________ Physician's signature ____

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3. Based on review of the accompanying pages, the probable cause of the indicated (respiratory disease) (hypertension) (heart disease) is the applicant's employment as a (deputy sheriff) (firefighter).

Date:_______________ Physician's signature ____

B. There (is) (is not) contrary medical opinion to the finding made above contained in the file.

Date:_______________ Physician's signature ____

C. A review of the applicant's medical file discloses that the applicant (was) (was not) found free of the above (respiratory) (hypertension) (heart disease) during his or her pre-employment physical.

Date:________________ Physician's signature ____