Form EMPLOYEES' RETIREMENT SYSTEM

Member's Report on Disability of Member

INSTRUCTIONS: Type or print your entries in ink. Complete all items 1 through 18. Be certain to complete items 16 and 17 in detail. Sign the statement in item 18 and return it to the office of the Board of Trustees of the Fairfax County Employees' Retirement System.

1. Last name / First name / Middle Name	2. Date of Birth	3. Social Security Number

4. Present Address	5. Date when disability began	6. Amount of time lost from work in past 12 months because of disability

7. Position (use classification or payroll title)	8. Division and Department	9. Was disability incurred in performance of duties?

10. Name of Family Physician	11. Family Physician's Address

12. Name of any other physician who treated this disability	13. Address of other physician

14. Name of hospital or other clinic where disability was treated	15. Address of hospital or clinic

16. Name and describe the disability

17. Tell how this disability prevents you from performing the duties of your position.

18. Member's Statement. This Statement of Disability has been made as part of my application for disability retirement under the provisions of the Fairfax County Employees' Retirement System Ordinance. I hereby authorize my physician or physicians to report on my disability to the Medical Examining Board and the Board of Trustees of the Fairfax County Employees' Retirement System. I agree to appear for examination by the Medical Examining Board at such time and place as required.

_____ _____

Date **Signature of Member**

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

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