Print Form

# City of St. Joseph
# Employees Retirement System

## Application for Disability Retirement

Submitted by: ☐ Member
☐ Department Head

| | | | |
|---|---|---|---|
| Applicant Name | | | Date of Birth |
| Address | | | Department |
| City | State | Zip Code | Job Title |
| State the nature of your disability? | | | |
| When did you first notice your disability? | | | Date you last performed Duties? |
| What duties can you not perform? | | | |
| Is your disability duty related? Please explain. | | | |
| Are you receiving workmen's compensation benefits? | | | |
| If your diability is the result of an accident, give names and addresses of witnesses. | | | |
| When did you first consult a physician about your disability? | | | |
| Provide names and addressess of all physicians you have consulted in connection with your disability. | | | |

| Name | Address | Dates Attended |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Give full explanation of the nature and causes of your disability.

The undersigned member hereby makes claim to the Employee Retirement System for disability benefits and authorizes the above named physicians who have attended him to report directly to the Medical Director of the Retirement System regarding his physical condition. The undersigned member agrees that the furnishing of this form or other forms supplemental thereto by the Retirement System is not to be considered nor constitute an admission of liability by the Retirement System.

Signature of Member _____ Date _____ Signature of Witness _____ Date _____

# City of St. Joseph
## Employee's Retirement System
### Medical Authorization Form

**TO: ANY HOSPITAL OR PHYSICIAN**

This authorizes you to permit the Board of the Employees Retirement System or its legal advisor(s) to examine information contained in the patient records concerning treatment or hospitalization accorded to the applicant below, Social Security number: _____. This authorization is for examination and treatment including history, diagnosis, course of treatment, and X-rays, as well as alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, social service records, if any, and psychological services records, if any, including my communications to a social worker or psychologist.

This also authorizes you to furnish the Board of Employees Retirement System with a copy of records, medical reports, and X-rays relating to the above-mentioned treatment. Thank you.

_____ _____

Applicant Date

_____

Notary Public, _____ Berrien County

# City of St. Joseph
## Employee's Retirement System
Decision of Examining Physician

RE: WHETHER _____ IS DISABLED.
(name of applicant)

*The undersigned state that they reviewed the available medical information regarding the application for disability retirement of the foregoing individual and make the following recommendation.*

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I/We find that the applicant **IS** (1) mentally or physically totally incapacitated for service in the employ of the Municipality, (2) that such incapacity will probably be permanent, and (3) that such applicant **SHOULD** be retired.

_____ _____
Signature Date

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I/We find that the applicant **IS NOT** (1) mentally or physically totally incapacitated for service in the employ of the Municipality, (2) that such incapacity will **NOT** probably be permanent, and (3) that such applicant **SHOULD NOT** be retired.

_____ _____
Signature Date

**PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO THE BOARD OF TRUSTEES OF THE EMPLOYEE'S RETIREMENT SYSTEM**

City of St. Joseph
Personnel Department
700 Broad Street
St. Joseph MI 49085
Phone: (269) 983-5541 Fax: (269) 985-0346