CITY OF FORT LAUDERDALE
GENERAL EMPLOYEES' RETIREMENT SYSTEM

316 NE Fourth Street, Suite 2
Fort Lauderdale, FL 33301

DOCTOR'S SUMMARY FOR DISABILITY APPLICATION

Please mail this form along with all-pertinent medical documentation regarding the patient's claim for disability to our Office in the enclosed envelope.

Please Print or Type

Name of Patient: _____

Date of First Exam: _____

Date of Most Recent Exam: _____

Date the injury or illness prevented the patient from performing any or all job related functions:

_____

Was the Patient Referred to you: _____Yes _____No

If yes, Name and Address of Referring Doctor: _____

_____

Have you referred the Patient to another Doctor: _____Yes _____No

If yes, Specialty: _____

Name and Address of the Doctor: _____

_____

Conclusion:

What is your medical diagnosis of the Patient and your recommended Treatment / Medication:

_____

_____

_____

_____

In Your Medical Opinion:

Did the patient's injury, disease or disability occur:

_____ On-the-Job or _____ Off-the-Job

1. Has the Patient reached Maximum Medical Improvement: _____Yes ____No

   If yes, at what date: _____/_____/_____

2. Is the Patient now able to perform the Regular and Continuous Duties of Employment as outlined in the provided Job Description: ____Yes ____No*

   *If no, do you feel the patient will be able to perform those duties in the future: _____Yes _____No

3. Is the patient, at present time, incapacitated from performing any duties for gainful employment: _____Yes* _____No

   *If yes, do you feel the patient will be able to perform any duties for gainful employment in the future: ___Yes ____No

4. If the Patient is capable of performing any "light duty" functions, please explain what employment Restrictions should be imposed:

_____

_____

Please attach any additional medical comments or Explanations

Print Name of Physician _____

Specialty _____

Address _____

_____

Telephone _____ Fax _____

Signature _____ **Date** _____

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