Form POLICE Officers RETIREMENT SYSTEM

Application for Disability Retirement

Last Name:	First Name:		
Date of Birth:	Social Security #:		
Address:	City:	State:	Zip:
Personal Phone #:	Work Phone #:		
Email Address:	Agency and Position:		
Spouse Name:	Spouse SSN:	Spouse DOB:	
Dependent Name(s):	SSN:	DOB:	
Primary Beneficiary Name: *(if no spouse or dependents)*	SSN:	DOB:	

Request for Ordinary Disability Retirement: Under the provisions of the Fairfax County Police Officers Retirement System Ordinance, I hereby apply for Ordinary Disability Retirement because a disability prevents me from performing the duties of my position. The disability is described on the attached form. I have completed five or more years of service for Fairfax County.

(You must provide birth certificates for both yourself and your spouse and any dependent eligible for the automatic benefit. Plus, a copy of your marriage license)

Employee Signature: Date:

Request for Service-Connected Disability Retirement: Under the provisions of the Fairfax County Police Officers Retirement System Ordinance, I hereby apply for Service-Connected Disability Retirement because of a disability incurred in the performance of my duties which prevents me from performing the duties of my position. The disability is described on the attached form.
I hereby acknowledge receipt of the "Preparing for Disability Retirement Guide".

(You must provide birth certificates for both yourself and your spouse and any dependent eligible for the automatic benefit. Plus, a copy of your marriage license)

Employee Signature: _____ Date: _____

Supervisor acknowledgement MUST be received PRIOR to submission to the Retirement Systems. (Please keep a copy of this for your records.)

Supervisor Signature: _____ Date: _____

FAIRFAX COUNTY Retirement SYSTEMS
EMPLOYEES' POLICE Officers UNIFORMED

Fairfax County Retirement Systems
12015 Route 50 ∗ Suite 350 ∗ Fairfax, VA 22033
703-279-8200 ∗ TTY: 711 ∗ 1-800-333-1633 ∗ Fax: 703-653-9543
www.fairfaxcounty.gov/retirement/

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Release of Records
Member's Statement

I hereby authorize my health care providers and previous employers to release any and all medical records on my previous physical condition and treatment to the Board of Trustees of the Police Officers Retirement System and/or Board Investigator. For purposes of this release, health care providers shall include, but are not limited to, all physicians, psychologists, psychiatrists, clinics, hospitals, and governmental or quasi-governmental agencies. Medical records include, but are not limited to, medical reports, test results, and any other information bearing upon my physical or mental condition. This release also applies to any and all Police Officers Personnel records including, but not limited to, my application for employment. The medical records and personnel records will be disclosed for the purpose of evaluating the member's application for disability retirement, and may be disclosed to the members of the Board of Trustees, the staff of the Retirement Systems, the consulting physicians, experts and attorneys for the Retirement System, and the independent medical examiner chosen to evaluate the member. Such release shall remain valid until such time as I am no longer receiving disability benefits.

This statement of disability has been made as part of my application for disability retirement under the provisions of the Fairfax County Police Officers Retirement System's Ordinance. This application represents a true and accurate statement of my medical condition.

Employee Signature: _____ **Date:** _____

Print Name: _____

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