NYCERS USE ONLY **F609**

NYCERS NYC Employees' Retirement System

Mail Completed Form to:
335 Adams Street, Suite 2300
Brooklyn, NY 11201-3724

Questionnaire for Disability Retirement Applicants

Member Number	Last 4 Digits of SSN	Phone Number	Date of Birth [mm/dd/yyyy]

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

To NYCERS' Medical Board:

I, the undersigned, believe that I am incapacitated for further service as a _____
Your Job Title

in the Department of _____
Your Agency

due to the disabling conditions listed on my Application for Disability Retirement.

Questions 1-17 are to be completed by ALL members applying for Disability Retirement.

1. What is the name of your union, and local?

_____

2. Did you have previous service with New York City or New York State prior to your current membership?

☐ Yes ☐ No

If yes, provide a start date and an end date for each period of service:

Period of Service	Start Date Month	Start Date Year	End Date Month	End Date Year	Period of Service	Start Date Month	Start Date Year	End Date Month	End Date Year
1.					3.				
2.					4.				

3. Are you a veteran?

☐ Yes ☐ No

If yes, name the branch(es) you served in, and provide a start and end date for each period of service:

Branch of Service	Start Date Month	Start Date Year	End Date Month	End Date Year	Branch of Service	Start Date Month	Start Date Year	End Date Month	End Date Year

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4. List the name(s) of doctors or institutions from whom you are receiving, or have received in the past, treatment for your alleged conditions, including address(es) and frequency of visits:

Name of Doctor or Institution	Address	Frequency of Visits

Note: The Physician's Report of Disability must be completed by each doctor listed above and submitted with your application.

5. When did your symptoms begin?

_____ / _____ / _____
Month *Day* *Year*

6. List the nature of treatment, including medications being taken:

Treatment	Medication	Frequency

7. Check boxes below to indicate tests performed (submit a copy of ALL REPORTS, if possible):

- ☐ Blood and Urine
- ☐ X-Rays
- ☐ EMG (Electromyogram)
- ☐ EKG (Electrocardiogram)
- ☐ Myelogram
- ☐ CT scan
- ☐ Stress Test
- ☐ Pulmonary Function studies
- ☐ Pathology or Biopsy Reports
- ☐ Other _____

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8. I have been hospitalized and/or treated for this condition at the following hospital(s) and/or medical group(s):

Name of Hospital/ Medical Group	Address	Date of Admission	Date of Discharge	Diagnoses	Was surgery performed?
					☐ Yes ☐ No If Yes, provide date:
					☐ Yes ☐ No If Yes, provide date:
					☐ Yes ☐ No If Yes, provide date:
					☐ Yes ☐ No If Yes, provide date:
					☐ Yes ☐ No If Yes, provide date:

Note: An appropriate authorization for release of medical information must be completed for each hospital and/or medical group listed above, and submitted with your application.

9. Do you feel that you are totally and permanently disabled from performing the usual duties of your title?

☐ Yes ☐ No

10. Are you working now?

☐ Yes ☐ No

If no, when did you stop?

_____ / _____ / _____
Month *Day* *Year*

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11. Did you file for Social Security Disability Benefits?

☐ Yes ☐ No

12. Are you receiving Social Security Disability payments?

☐ Yes ☐ No

If Yes, how much monthly?

$

13. Did you file a Workers' Compensation claim?

☐ Yes ☐ No

14. Are you receiving Workers' Compensation payments?

☐ Yes ☐ No

If Yes, how much bi-weekly?

$

15. Do you drink alcohol?

☐ Yes ☐ No

If Yes, how often?

How much?

16. Do you take any medications daily?

☐ Yes ☐ No

If Yes, what?

17. Do you use any recreational drugs?

☐ Yes ☐ No

If Yes, what and how often?

If you are NOT filing for accidental disability, skip to page 6 and sign.

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Questions 18-33 are to be completed ONLY by members applying for Disability Retirement as a result of an incident that occurred while performing their job duties while in City service, or who have filed for a Performance-of-Duty Disability Retirement.

18. What is the date that the injury occurred?

____ / ____ / ____
Month *Day* *Year*

19. Were you on full duty at the time of the injury?

☐ Yes ☐ No

20. Were you performing any unusual work at that time?

☐ Yes ☐ No

If Yes, describe:

21. What were you doing when you were injured?

22. What part of your body was injured?

23. How were you injured?

24. Were there any witnesses to the incident when you were injured?

☐ Yes ☐ No

If Yes, give Name, Title and Address (if known):

25. When did you stop working because of the injury?

____ / ____ / ____
Month *Day* *Year*

26. Do you have proof of this occurrence?

☐ Yes ☐ No

If Yes, submit supporting documentation with this questionnaire.

27. When were you first treated for the injury referred to above, and by whom?

Date ____ / ____ / ____
Month *Day* *Year*

By whom? ____

Place? ____

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28. List the name(s) of doctors or institutions who treated you for the injury described, including address(es) and frequency of visits:

Name of Doctor or Institution	Address	Frequency of Visits

29. Have you had any similar disability before the incident?

☐ Yes ☐ No

30. Have you had any other accidents or incidents on the job (either before or after the incident claimed herein)?

☐ Yes ☐ No

If Yes, give dates and description of injury:

Month	Day	Year	Description
/	/		
/	/		
/	/		

31. Have you had any accidents or injuries off the job?

☐ Yes ☐ No

If Yes, give dates and descriptions of injury:

Month	Day	Year	Description
/	/		
/	/		
/	/		

32. Did you return to light duty after the incident herein claimed?

☐ Yes ☐ No

If Yes, when?

Start date: ____ / ____ / ____
Month *Day* *Year*

End date: ____ / ____ / ____
Month *Day* *Year*

33. Did you return to full duty after the incident herein claimed?

☐ Yes ☐ No

If Yes, when?

Start date: ____ / ____ / ____
Month *Day* *Year*

End date: ____ / ____ / ____
Month *Day* *Year*

I will appear before NYCERS' Medical Board at 340 Jay Street, Mezzanine Level, in downtown Brooklyn when I am scheduled to be examined.

Note: If you are unable to appear before NYCERS' Medical Board for examination, please forward your physician's certificate stating why.

Signature of Member **Date**
