NYCERS USE ONLY **F609**

Questionnaire
Applicants for Disability Retirement

This application is to accompany your application for Disability Retirement. Please be sure you read and understand the questions asked on this form before answering. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN

First Name	M.I.	Last Name

This section must be completed by ALL members applying for Disability Retirement.

1. What is (are) the disabling condition(s) which is (are) the basis for your applying for disability retirement?

2. Check all relevant boxes that indicate your symptoms
   - ☐ Pain ☐ Weakness ☐ Difficulty Walking
   - ☐ Weight Loss ☐ Depression ☐ Other _____

3. When did symptoms begin? [MM/DD/YYYY] / /

4. Please list the name(s), address(es) and frequency of persons and/or institutions from whom you are receiving treatment.

5. Nature of treatment, including medications being taken.

6. Check boxes below to indicate tests performed: **(Bring 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 _____

7. Hospital admission(s): (Hospital Reports must be supplied to this office.)

   (A) Name of hospital(s):

   1). _____

   2). _____

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(B) Dates of admission and discharge:

1). _____

2). _____

(C) Diagnosis(es):

1). _____

2). _____

Was surgery performed? ☐ **Yes** ☐ **No** If Yes, give dates and type of surgery performed.

1). _____ [MM/DD/YYYY] / /

2). _____ [MM/DD/YYYY] / /

8. Check all relevant boxes that your job requires.

☐ **Lifting** ☐ **Working Outdoors** ☐ **Walking** ☐ **Climbing** ☐ **Other** _____

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

☐ **Yes** ☐ **No**

Could you do other work? ☐ **Yes** ☐ **No**

10. Are you working now? ☐ **Yes** ☐ **No**

If Not, when did you stop? [MM/DD/YYYY] / /

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

12. Are you receiving Social Security Disability Benefits? ☐ **Yes** ☐ **No**

13. Please give a daytime telephone number where you can be reached. ( )

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

☐ **Yes** ☐ **No**

If yes, When? [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / /

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This section is to be completed ONLY by members applying for disability retirement as a result of an accidental injury during the performance of their duties while in City service.

15. What is your date of birth? [MM/DD/YYYY] / / (Attach a copy of your Birth Certificate.)

16. What was the date of the injury? [MM/DD/YYYY] / /

17. What part of your body was injured?

18. What were you doing when you were injured?

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 is the nature of the injury?

22. How were you injured?

23. Were there any witnesses to the incident when you were injured? ☐ **Yes** ☐ **No**
If Yes, give Name, Title and Address (if known).

24. When did you stop working because of the injury? [MM/DD/YYYY] / /

25. Do you have proof of this occurrence? ☐ **Yes** ☐ **No**

26. When were you first treated for the injury referred to above, and by whom?
Date [MM/DD/YYYY] / /
By Whom?
Place?

27. State the name of medical persons or institutions who treated you for the injury described. State dates and frequency.
[MM/DD/YYYY]
Name of Person or Institution / /
Name of Person or Institution / /
Name of Person or Institution / /

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28. Have you had any similar disability before the injury? ☐ **Yes** ☐ **No**

29. Have you had any other accidents or injuries on the job (either before or after the injury claimed herein)?

☐ **Yes** ☐ **No**

If Yes, give dates and description of injury _____ [MM/DD/YYYY] / /

_____ / /

30. Have you had any accidents or injuries off the job? ☐ **Yes** ☐ **No**

If Yes, give dates and descriptions of injury _____ [MM/DD/YYYY] / /

_____ / /

31. Did you return to full duty after the injury herein claimed? ☐ **Yes** ☐ **No**
If Yes, When? / / [MM/DD/YYYY]

32. Did you return to light duty after the injury herein claimed? ☐ **Yes** ☐ **No**
If Yes, When? / / [MM/DD/YYYY]

33. Are you being treated for any other injuries/disorders? ☐ **Yes** ☐ **No**
If Yes, describe injury/disorder and treatment.

_____

34. Do you drink alcohol regularly (one-half pint or more per-week)? ☐ **Yes** ☐ **No**
Do you drink occasionally? ☐ **Yes** ☐ **No**

If yes, how often? _____

How much? _____

35. Do you take any medications daily? ☐ **Yes** ☐ **No**

If Yes, What? _____

36. Do you use any recreational drugs? ☐ **Yes** ☐ **No**

If Yes, What and how often? _____

37. Did you file a Workers' Compensation claim? ☐ **Yes** ☐ **No**

Are you receiving Workers' Compensation payments? ☐ **Yes** ☐ **No**

38. If Yes, how much bi-weekly? _____

Signature of Member | **Date**