NYCERS USE ONLY **F613**

Final Medical Review Waiver (To be completed by Member)

Member Number	Date [MM/DD/YYYY]
	/ /

I, the undersigned, do hereby provide that the execution and filing of this Waiver with the New York City Employees' Retirement System shall constitute an agreement by me that my application for disability retirement shall be disposed of by action of Special Medical Review Committee pursuant to Section 13-169 of the Administrative Code of the City of New York or Section 605e of the Retirement and Social Security Law; that such action of the Special Medical Review Committee shall be final and conclusive, and that I waive any and all rights that I might otherwise have to seek or obtain any other disposition of such application for disability retirement by a Court, including but not limited to an Article 78 CPLR Proceeding, administrative proceedings or otherwise.

I understand that this Waiver shall be effective and binding upon me in accordance with the terms stated herein.

Signature of Member	Date

First Name	M.I.	Last Name

In care of (if Applicable)

Address	Apt. Number

City	State	Zip Code

This form must be acknowledged before a Notary Public or Commissioner of Deeds

State of _____ County of _____ On this ____ day of _____ 2 0____, personally appeared before me the above named, _____, to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

If you have an official seal, affix it

Signature of Notary Public or Commissioner of Deeds _____

Official Title _____

Expiration Date of Commission _____

Sign this form and have it notarized, THIS PAGE

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