NYCERS USE ONLY

**F605**

## Applicant's Report of Personal Disability

**Please return with member's application for disability retirement.**

| Membership Number | Last 4 Digits of SSN | 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

Title ____________________

in the Department of ____________________

because ____________________

____________________

____________________

I am being treated for this condition by the following doctor(s):

**Name of Doctor(s) and Addresses** ____________________

____________________

____________________

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

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

| **Name of Hospital(s) and/or Medical Group(s) and Addresses** | **Treatment Dates** [MM/DD/YYYY] |
|---|---|
| | / / |
| | / / |
| | / / |

**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

I will appear before NYCERS' Medical Board at 340 Jay Street, Mezzanine Level, in downtown Brooklyn when necessary for me 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** |
|---|---|
| | |