SR-13b
Rev. 09/71
Disability Determination

STATE AND COUNTY OFFICERS' AND EMPLOYEES RETIREMENT SYSTEM
PHYSICIAN'S REPORT OF DISABILITY

PO Box 9000
Tallahassee, FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725

APPLICANT'S FAMILY PHYSICIAN MUST COMPLETE THIS FORM

Social Security No._____

From: _____M.D.

Date:_____

Address: _____

_____

Telephone: _____

Subject: Physician's Report of Disability: Name of Applicant: _____

Home Address: _____

Present Employer: _____

This is to certify that _____has been under my personal care since _____.
(Patient Name) (Date)

The subjective and objective symptoms of which said employee complains are as follows:

DIAGNOSIS: _____

_____

_____

TREATMENT: _____

_____

_____

PROGNOSIS: _____

_____

_____

In my opinion, by reason of the above described condition, the above named application (is) (is not) totally and incapacitated for further performance of duty, (he) (she) is (likely) (not likely) to be incapacitated permanently and therefore (he) (she) (should) (should not) be retired. Disability (is) (is not) in-line-of-duty.

Signed: _____M.D.