TR-13e
Rev. 02/88
Disability Determination

Teacher's Retirement System
Retiree's Report of Continuing Disability

PO Box 9000
Tallahassee FL 32315-9000
850-907-6500
Toll Free: 1-844-377-1888

Please Print or Type

Date: ______________________

Retiree's Name: ______________________ SSN: ______________________

Mailing Address: ______________________ Telephone #: ______________________

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A. **Instructions:** Please read carefully before completing this statement.

Section 238.07 (12), Florida Statues, provides for the periodic reevaluation of all individuals receiving disability benefits under the Teacher's Retirement System. The Division of Retirement authorizes the physician who is now treating or who last treated you disabling conditions to complete Form TR-13f, Physician's Report of Reexamination. You should complete Form TR-13e, Retiree's Report of Continuing Disability. When complete, both forms should be sent to the Division of Retirement, PO BOX 9000, Tallahassee, FL 32315-9000. Should the physician charge for completing Form TR-13f, a copy of his bill must be attached to the forms so that the Division of Retirement can issue you a warrant to pay for such charges.

Please furnish the Division with the requested information within sixty (60) days from the date you receive these forms. In the event you cannnot furnish this information within the sixty (60) days, notify the Disability Determination Section by writing the Division of Retirement or by calling 844-377-1888 toll free or 850-907-6500.

B. **Medical Treatment Subsequent to Disability Retirement**

1. Since the date of your disability retirement or the date you last completed a Disability Evaluation Statement:

   a. Have you received medical or therapeutic treatment of any kind?

   ☐ YES ☐ NO (If "yes", please explain below)

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B. **Medical Treatment Subsequent to Disability Retirement -** continued

b. Have you been under the regular care and supervision of a physician?

☐ Yes ☐ No (If "yes", please explain below.)

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c. Have you submitted to any surgical procedure?

☐ Yes ☐ No (If "yes", please provide the date and type of surgery.)

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d. Please provide the name and address of any physician, clinic or other medical or rehabilitative from who you received treatment:

Date Treatment Received	Name of Physician or Institution	Address

C. **Employment Since Disability Retirement**

1. Since the date of your disability retirement or the date you last completed a Disability Evaluation Statement, have you ever been employed in any capacity?

☐ Yes ☐ No (If "yes", please provide the information requested on the following page.)

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Section 238.07 (12)(b), Florida Statutes, requires that it be certified to the Division of Retirement when a retired disabled member is employed and at what rate of pay. Please complete the following chart and be sure to include the exact annual compensation received from each employer. Should additional space be required, please attach a separate sheet.

1. Dates of Employment	2. Dates of Employment
Employer	Employer
Position Held	Position Held
Descriptions of Duties	Descriptions of Duties
Gross Annual Salary (show total for each year worked)	Gross Annual Salary (show total for each year worked)
Reasons for Terminating	Reasons for Terminating

2. Have you ever received disability benefits from Social Security, Worker's Compensation, Veterans' Administration, or any other public or private agency?

☐ Yes ☐ No (If "yes", please list the source of those benefits received.)

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3. Have any of these disability benefits been terminated?

☐ Yes ☐ No (If "yes", please specity and explain why.)

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1. Do you feel you are still unable to perform the duties of the job you held prior to your disability retirement?

☐ Yes ☐ No (If "yes", please specifiy and explain why.)

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2. Do you feel you are capable of engaging in any gainful employment?

☐ Yes ☐ No (If "no", please explain.)

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3. If you have any additional comments you wish to make concerning your present condition, please provide them in the following space. Should additional space be required, please attach a separate sheet.

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Release of Information:

I affirm that all information and statements provided on this form are true and correct to the best of my knowledge.

I hereby authorized any physician, hospital or clinic to give full and complete disclosure concerning me or my medical condition including prior history to the Division of Retirement, Department of Management Services, State of Florida, or its authorized representative.

In addition to the above general medical release, I hereby specifically authorize the release of any records which may exist concerning me, including but not limited to employment or personnel records with previous employers, records with other Retirement Systems, with the Veteran's Administration, Social Security Administration, employment or personnel records with a School Board (Public or Private), Community College, Major University or any other records and reports which the Division of Retirement may deem necessary in their investigation of my application for retirement and for which a personal release signed by me may be required.

Please cooperate fully with the bearer of this release.

_______________________ _______________________
Name of Applicant Signature of Applicant

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Date