The Pension Administrator shall contact the Medical Committee to schedule appointments for physical examination based on the injury and which shall also include all tests required for the employment physical examination.

DISABILITY EXAMINATION

Members may be retired by the Board of Trustees for **permanent** and **total** disability incurred **in the line of duty** (this is classified as a Service Connected Disability); or for **permanent** and **total** disability incurred **other than** in the line of duty (this is classified as an Ordinary Disability).

In the case of disability examinations, one of the doctors shall be the Chairperson. The Chairperson shall make a full and complete physical examination which shall include all the tests required for the employment examination. Each of the other two doctors on the Medical Committee shall also give a complete physical but not the other tests required for the employment physical.

The Chairperson of the Medical Committee is permitted to arrange for further testing, or to refer the member to a consulting physician, if deemed necessary. In either case, authorization from the Pension Administrator is required.

The Medical Committee shall then, through the Chairperson, submit a written report to the Board of Trustees clearly stating its opinion as to whether the Applicant's disability is total, permanent, and, if applicable, service incurred. This report shall be signed by each member of the medical Committee. If a doctor is not in agreement for any reason, that doctor shall submit his own report which will be attached to the Chairperson's report. Records of all tests shall also be included.

The Board of Trustees may have the opportunity to request the appearance of the doctors on the Medical Committee at one of the Informal or Formal disability hearings before the Board of Trustees for the purpose of making oral inquiries concerning any of the facts and findings of said medical Committee.

PROCEDURES

1. Member executes application for Disability Retirement.
2. Member provides medical records.
3. Member signs medical records release authorization forms.

MEDICAL COMMITTEE

The Pension Administrator shall designate a Medical Committee to be composed of three physicians.
The Medical Committee shall:

(1) arrange for and pass upon all medical examinations required under the provisions of the Clair T Singerman Employees' Retirement System, Ordinance #691.

(2) investigate all essential statements or certificates made by or on behalf of a member in connection with an application for disability retirement.

(3) report in writing to the Board of Trustees its conclusions and recommendations upon all matters referred to it.

The doctor conducting the examination is permitted to arrange for further testing or to refer the member to a consulting physician, if deemed necessary. In either case, notification to the Pension Administrator should be given.

All records are provided to the Pension Administrator. The medical Committee shall report in writing to the Board of Trustees its conclusions. The report shall include the completed Personal History Form and Physician's Statement Form. Blank history and statement forms are supplied to the doctors on the Medical Committee by the Pension Administrator. Medical records are kept in member's own file and may be released to the member upon request. Medical records cannot be released without authorization from the member.

The Member's employment physical is a permanent record of the physical state of the member at date of hire. This would indicate any condition which existed at the time of examination and could prevent any subsequent attempt to claim permanent and total disability on the basis that it was service incurred.

CLAIR T. SINGERMAN EMPLOYEES' RETIREMENT SYSTEM, ORD. #691

GENERAL INFORMATION

After examination by all three Medical Committee doctors, the Medical Board shall then, through the Chairperson, submit a written report to the Board of Trustees clearly stating its opinion as to whether the applicant's disability is TOTAL, PERMANENT, and SERVICE INCURRED (if applicable). This report shall be signed by each member of the Medical Committee. If a doctor is not in agreement for any reason, that doctor shall submit his own report which will be attached to the Chairperson's report. Records of all tests shall also be included.

The Chairperson of the Medical Committee is permitted to arrange for further testing, or to refer the member to a consulting physician, if deemed necessary. In either case, authorization from the Chairperson of the Board of Trustees is required.

The Personnel Department prepares the final "Disability Packet" which will be distributed to the Board of Trustees, Counsel, Applicant, and the Applicant's attorney (when applicable). This packet includes:

a. Application for Disability
b. Guidelines for Disability Hearing
c. 1st Report of Injury or Illness (if applicable)
d. City of North Miami Supervisor's Report (if applicable)
e. Presumptive Act (if applicable)
f. Job Specifications
g. Letter from Medical Committee with backup of physical examination
h. Medical at time of Employment
i. Medical Records (in date order)
j. Miscellaneous information

The application for disability retirement is placed on the next available agenda (the date of which is agreeable to all concerned parties). There shall not be a disability hearing when there is a scheduled appearance of the Fund Manager.

When the disability hearing commences, Counsel will explain the procedure of an informal hearing to the Applicant. This is summarized as follows:

At the informal hearing the Board does not entertain any evidence other than the written material it has before it. The applicant, as in all cases, bears the burden of demonstrating to the Board that the disability is of a (1) total, (2) permanent and (3) service incurred (if applicable). In the case of a police officer where there is a claim of condition which is within the guidelines of the FSS Chapter 185.34 which relates to either tuberculosis, hypertension, or heart disease, there is a presumption that it is accidental and incurred in the line of duty if there was successful examination when entering the service which failed to reveal such condition. In the case of a police officer where there is a claim of condition which is within the guidelines of FSS Chapter 112.181 which relates to either hepatitis, menigococcal meningitis, or tuberculosis, there is a presumption that it is accidental and incurred

in the line of duty if there was successful examination when entering the service which failed to reveal such condition. These presumptions only supply the element of "service incurred". Any presumption does not apply to whether disability claim is total or permanent. After the evidence is in, a motion will be in order. Each Trustee shall be entitled to one vote on the Board. Five (5) votes shall be necessary for a decision by the Trustees at any meeting. A motion to grant will terminate the hearing; a motion to defer is in order should the Board require additional information, or the appearance of a doctor; a motion to deny which under another statute requires grounds (which could be on the basis that it is not total, not permanent, not service incurred) would lead to a formal step is requested by the Applicant within thirty (30) days.

If the Applicant files a Formal Hearing, the following procedure will take place:

1. After such notification, the Applicant or Applicant's attorney should notify the Board's attorney in order to work out mechanics such as discovery and a mutually convenient time for hearing the application. However, in all cases, at least sixty (60) days prior to the hearing, the Applicant or Applicant's attorney **must** (a)provide the Board and its attorney with copies of all medical reports or other relevant documentary evidence in Applicant's possession or of which Applicant has knowledge, (b)provide the Board's attorney a list of names, addresses and telephone numbers of each and every witness Applicant claims has knowledge relating to the application, and (c)provide the Board's attorney with a short statement or summary of the testimony of each and every witness. In some cases, the sixty (60) business day period is not sufficient; in such cases, the Board's attorney will advise the Board that the matter should be postponed until a later date.

2. After all new information is received a supplemental packet is prepared and distributed to the Medical Committee by the Pension Administrator.

3. After review of new information by the Medical Committee, the Chairperson of the Medical Committee will either amend the Medical Committee letter or indicate that the Medical Committee did not change the conclusion(s).

4. The Supplemental Medical Packet is distributed to the Board of Trustees and the Board's attorney for review. Copies are sent to the Applicant and Applicant's attorney.

5. A new disability hearing date is established on the next available agenda (the date of which is agreeable to all concerned parties). The original "medical packet" and the "supplemental packet" will be considered as evidence.

6. At the hearing, the Applicant carries no greater burden than normal because the hearing is, in essence, the initial presentation to the Board of additional evidence and legal argument.

7. If the Applicant is granted a disability retirement, it is effective the same date it was granted.

8. Notification that a disability retirement was granted is sent to the City Manager and Doctors on the Medical Committee by the Pension Administrator.

9. If the application is denied, and the Applicant wishes to pursue it further, the Applicant should obtain advice from Applicant's own attorney as to the deadlines and methods of review.

10. Notification that the disability retirement was denied is sent to all Doctors on the Medical Committee by the Pension Administrator.

CLAIR T. SINGERMAN EMPLOYEES' RETIREMENT SYSTEM
ORDINANCE 691
CITY OF NORTH MIAMI

APPLICATION OR DISABILITY RETIREMENT

I hereby apply for disability benefits from the Clair T. Singerman Employees Retirement System (Ordinance 691) of the City of North Miami as amended.

Name	Social Security Number
Department	Classification
Date of Birth (Proof of date required)	Name of Spouse
Date of Marriage (Marriage Cert. req)	Spouse's Social Security Number

CHILDREN UNDER AGE 22 (Birth Certificate required):

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

____ Ordinary Disability Retirement ____ Service Connected Disability

What disability do you claim?_____

_____

_____

What is the cause of your disability? _____

_____

If accident, date occurred: _____ Place: _____

APPLICATION/QUESTIONNAIRE FOR DISABILITY RETIRMENT
CLAIR T. SINGERMAN EMPLOYEES' RETIREMENT SYSTEM
ORDINANCE 691

DIRECTIONS:

EACH QUESTION MUST BE ANSWERED FULLY AND HONESTLY. PLEASE READ CAREFULLY. IF FURTHER SPACE IS REQUIRED ON ANY QUESTION, ATTACH ADDITIONAL PAGES, INDICATING THE NUMBER(S) TO WHICH THE INFORMATION APPLIES.

What is your:

a. Current Name: _____

b. All other names by which you have ever been known: _____

_____

c. Home Address: _____

_____

d. Home Telephone Number: _____

e. Work Telephone Number: _____

f. Employee Number: _____

g. Date of Employment: _____

h. Status of Employment: _____

i. Date of Birth: _____

j. Social Security Number: _____

k. Address of all residences for last 5 years: _____

_____

_____

_____

How does your claimed disability affect your work? _____

_____

_____

_____

_____

Under whose employ were you when injured? (Copy of accident report and/or supervisor's injury report required): _____

_____

_____

To facilitate the Board of Trustees of the Clair T. Singerman Employees' Retirement System , Ordinance 691 of the City of North Miami in carrying out their duty to review, discuss and determine my application for disability retirement, I hereby waive my right to confidentiality of my medical records and other medical evidence in the custody of the Board of Trustees or elsewhere. In so doing, I understand such records will be discussed during one or more public meetings and will become public record. I understand that the Board will rely upon this waiver and that I will not be able to withdraw same at a later date.

I agree to cooperate with the Board of Trustees in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of continuing eligibility for payment of pension benefits from the plan. In the event I do not so cooperate, the Board, or authorized agents of the Board, is hereby authorized to obtain such information without additional consent. I hereby consent, on behalf of myself and any other person entitled to receive monies or benefits by virtue of this application and any resultant pension, to investigations (of any nature, type, manner or means) of matters which would in any way bear upon the obligation of the Board of Trustees to pay or continue to pay monies or benefits on account of this application and any resultant pension, at any time and from time to time, without further consent by or notice to anyone including myself, whether conducted by the Board of Trustees or on its behalf, and regardless of whether or not such investigations and/or reports or results thereof are within the scope of the Fair Credit Reporting Act and/or any other Federal, State or Local law.

I understand that any charges to the pension plan from Applicant's physicians or hospitals for medical reports, copying costs, postage, etc. may be invoiced to Applicant by the Board of Trustees and I agree to pay all such charges.

_____ _____

Signature of Applicant Date

_____ _____

Witness Date

4. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based.

a. Specifically state when you had these conditions.

b. Provide names, addresses and phone numbers of all health care providers (including chiropractors) whom you consulted or who treated you for the previous condition(s).

c. Provide the diagnosis.

d. Provide the prognosis.

e. Provide the dates of treatment.

a. Provide a brief description of what you were treated for.

b. Provide the diagnosis.

c. Provide the prognosis.

d. Provide the dates of treatment.

a. When the accident occurred.

b. Where the accident occurred.

c. How the accident occurred.

d. Whether you were injured.

e. How you were injured.

f. Was this accident job related?

g. Names, addresses and telephone numbers of <u>all</u> health care providers who treated you.

m. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the accident.

7. Have you ever had a fall, collision, sports injury, accident, etc. which required treatment by a health care provider? If so, please provide:

a. A description of the incident.

b. When it occurred.

c. How it occurred.

d. Where it occurred.

j. Nature of treatment.

k. Dates of treatment.

l. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the incident.

8. Please provide the names, addresses and dates of all of your prior and current employers, and provide:

10. Were you suffering any injury, disease, or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

11. Describe all records of the accident(s) or incident(s) forming the basis of your application for disability retirement, including but not limited to, traffic accident reports, police reports, notice of injury reports, log books, hospital/clinic records, doctor's records, disciplinary records, etc.

12. Provide the name and address of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a (_____) as a result of the injury or condition for which you seek disability retirement.

16. Is the injury which you are now claiming permanently and totally prevents you, physically or mentally, from performing useful and efficient service as a (_____) in any way related to any other injury, disease, condition or disability? If yes, explain.

17. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the injury or disability for which you seek disability retirement? If so, state the date taken and by whom.

20. Describe in detail why you feel that vou are permanently and totally unable physically or mentally, from performing useful and efficient service as a _____.

23. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based.

a. Specifically state when you had these conditions.

b. Provide names, addresses and phone numbers of all health care providers (including chiropractors) whom you consulted or who treated you for the previous condition(s).

c. Provide the diagnosis.

d. Provide the prognosis.

e. Provide the dates of treatment.

a. Provide a brief description of what you were treated for.

b. Provide the diagnosis.

c. Provide the prognosis.

d. Provide the dates of treatment.

25. Were you suffering any injury, disease, or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

26. Provide the name and address of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a (_____) as a result of the disease or disability for which you seek disability retirement.

27. Provide the names and addresses of all health care providers who have advised you that you are not permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a (_____) as a result of the injury or condition for which you seek disability retirement.

30. Please provide the names, addresses and dates of all of your prior and current employers, and provide:

a. The nature of the work involved with each employment.

b. The status (i.e. terminated, continuing, etc.) of each employment.

c. State the basis or reason for such status.

34. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the disease or disability for which you seek disability retirement? If so, state the date taken and by whom.

35. Is there any other information known to you, your agents and attorneys, which might be relevant to your application for disability retirement? If so, specify.

STATE OF FLORIDA
COUNTY OF _____

I HEREBY CERTIFY that on this day before me, an officer duly authorized in the State and County aforesaid to take acknowledgments, personally appeared _____ _____, Applicant, known to me to be the person described in and who executed the foregoing instrument and who acknowledged before me that _____ has read the above and foregoing answers and that same are true and correct, who is personally known to me or who has produced _____ as identification and who did take an oath.

WITNESS my hand and official seal in the County and State last aforesaid this _____ day of _____, 20

_____
Notary Public

_____
(Printed Name of Notary)

My Commission Expires:

LIST OF PHYSICIANS

Please list below the names, addresses and telephone numbers of all physicians who have examined you:

1) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

2) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

3) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

4) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

5) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

6) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

7) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

8) Name: _____
Address: _____
City_____ State _____ Zip _____
Phone: _____

_____ _____
Signature Date

Clair T. Singerman Employees' Retirement System
ORDINANCE #691

AUTHORIZATION TO WAIVE CONFIDENTIALITY OF MEDICAL RECORDS

I,_____, do hereby authorize the waiver of my right to confidentiality of my medical records and other medical evidence in the custody of the Board of Trustees of Clair T. Singerman Employees Retirement System in the City of North Miami or elsewhere in carrying out its duty to review, discuss and determine my application for disability retirement. In so doing, I understand such records will be discussed during one or more public meetings and will become public record. I understand that the Board will rely upon this waiver and that I will not be able to withdraw same at later date.

_____ _____

Signature Date