

CITY OF FORT LAUDERDALE
GENERAL EMPLOYEES' RETIREMENT SYSTEM
PO Drawer 14250, Fort Lauderdale, Fl 33302

DOCTOR'S SUMMARY FOR DISABILITY APPLICATION

Please fax this form upon completion to our Office at 954-828-5270 then mail this form along with all-pertinent medical documentation regarding the patient's claim for disability to our Office in the enclosed envelope.

Please Print or Type

Name of Patient: _____

Date of First Exam: _____

Date of Most Recent Exam: _____

Date the injury or illness prevented the patient from performing any or all job related functions:

Was the Patient Referred to you: _____ Yes _____ No

If yes, Name and Address of Referring Doctor: _____

Have you referred the Patient to another Doctor: _____ Yes _____ No

If yes, Specialty: _____

Name and Address of the Doctor: _____

Conclusion:

What is your medical diagnosis of the Patient:

What is your recommended Treatment / Medication:
