

THE CITY OF BALTIMORE  
EMPLOYEES' AND ELECTED OFFICIALS'  
RETIREMENT SYSTEMS

7 East Redwood Street -- 13th Floor  
Baltimore, Maryland 21202-3470  
Phone 443-984-3200



**LINE-OF-DUTY DISABILITY APPLICATION**

**INSTRUCTIONS**

- You must have had an on-the-job accident to apply.
- Complete all answers clearly and completely.
- Be specific. Do not write "all" or "none."
- If there is not enough room on the application, use an additional sheet to complete your answer.
- You must have the application notarized.

**IMPORTANT NOTICE**

- When you sign this application, you are certifying under penalty of perjury that it is **complete and true**.
- If your application is not complete and true, **you may lose your benefit and you may be prosecuted**.

**RELEASES**

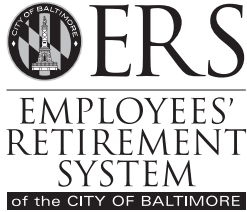
- You must submit the attached releases before your application will be considered.
- You must sign a release allowing your doctors to discuss your medical history with the Retirement System. See Appendix 1, attached.
- You must sign a release allowing the Retirement Systems to discuss your medical history with your department, Key Risk, the Office of the Inspector General, and other agents of the City of Baltimore. See Appendix 2, attached.
- You must sign the attached release allowing Mercy Medical Systems to discuss your medical history with the Retirement System.

**DOCTOR EXAMS AND RECORDS**

- If you receive any new medical records, you must promptly submit them to the Retirement Systems before the hearing.
- You must have your doctor assess your disability and ability to do your job. See Form 25, attached. If you do not submit the Form 25, your application will not be considered.
- You must have a doctor chosen by the Retirement Systems assess your disability and ability to do your job.

**HEARING**

- Your application will be determined at a hearing.
- Your testimony will be under oath.
- You, the claimant, must prove that you are permanently and totally disabled from the duties of your job classification, that your disability was caused by an on-the-job accident, and that you were not willfully negligent.
- If you are an ERS Class C or D member, you must also prove that the incapacity resulting from the accident caused at least 50% anatomical loss of any one or 25% loss of any two body parts specified in Baltimore City Code, Article 22 § 9(j)(5) or § 9.2(i)(5).
- You have the right to have an attorney with you at the hearing.



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## APPLICATION FOR LINE-OF-DUTY DISABILITY RETIREMENT

CHECK ONE:

- ☐ Employees' Retirement System of the City of Baltimore  
☐ Class C ☐ Class D  
☐ Elected Officials' Retirement System of the City of Baltimore

### OFFICE USE ONLY

Date Application Filed \_\_\_\_\_ Pension # \_\_\_\_\_

Creditable membership service on date of application: \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days

Applicant advised of his/her eligibility to apply for Service Retirement \_\_\_\_\_ Has applied? ☐ Yes ☐ No  
Applicant Initial

Verified by Retirement Benefits Analyst \_\_\_\_\_

Application taken under advisement? ☐ Yes ☐ No

Reason \_\_\_\_\_

I hereby apply for **LINE-OF-DUTY DISABILITY RETIREMENT** under Article 22 of the Baltimore City Code.

1. Full name of claimant \_\_\_\_\_

2. Social Security Number \_\_\_\_\_ 3. Date of Birth \_\_\_\_\_

4. Home address \_\_\_\_\_  
\_\_\_\_\_

5. Phone: Work \_\_\_\_\_ Home \_\_\_\_\_

6. Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never married

If married, name of spouse \_\_\_\_\_ Date of Birth \_\_\_\_\_

7. When did your employment with Baltimore City begin \_\_\_\_\_ end \_\_\_\_\_

8. Latest job classification \_\_\_\_\_

9. Department # and location \_\_\_\_\_

10. Most recent full-duty supervisor \_\_\_\_\_

11. What was your last full-duty job assignment in the employ of Baltimore City? \_\_\_\_\_

12. When did this job assignment begin \_\_\_\_\_ end \_\_\_\_\_

13. Was it a full-time job assignment? ☐ Yes ☐ No

If "No," explain \_\_\_\_\_

14. What were the principal duties of this job assignment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Do you have a disability that prevents you from further performance of the duties of your job classification? ☐ Yes ☐ No

If "Yes," explain \_\_\_\_\_

On what date did you become totally and permanently incapacitated? \_\_\_\_\_

16. Which of these duties are you now incapable of performing due to your disability? Be specific; **do not say "none" or "all."** \_\_\_\_\_

\_\_\_\_\_

17. Which of these duties are you still able to perform? Be specific; **do not say "none" or "all."** \_\_\_\_\_

\_\_\_\_\_

18. When was the last day that you performed actual work for the City of Baltimore? \_\_\_\_\_

19. Since you began working for the City of Baltimore, have you ever held any other employment? ☐ Yes ☐ No

If "Yes," answer (a) through (c):

(a) Name, Address and Telephone number of Employer \_\_\_\_\_

\_\_\_\_\_

(b) Hours of work \_\_\_\_\_

(c) Job duties \_\_\_\_\_

20. Do you presently hold any other employment? ☐ Yes ☐ No If "Yes," answer (a) through (c):

(a) Name, Address and Telephone number of Employer \_\_\_\_\_

\_\_\_\_\_

(b) Hours of work \_\_\_\_\_

(c) Job duties \_\_\_\_\_

21. What is the cause of your disability? (Name of injury or disease as diagnosed by your doctor) \_\_\_\_\_

\_\_\_\_\_

22. List the names and addresses of all doctors or other health providers who have treated you for this condition and dates of treatment. Attach additional sheets as necessary. \_\_\_\_\_

\_\_\_\_\_

23. If you were ever hospitalized for this condition, list the name of each hospital, dates hospitalized, and if known, your patient identification number. Attach additional sheets as necessary. \_\_\_\_\_

\_\_\_\_\_

24. Is your incapacity the result of an accident which occurred while you were in the actual performance of duty?

☐ Yes ☐ No If "Yes," answer (a) through (d):

- (a) Date and time the accident occurred \_\_\_\_\_
- (b) Place of accident \_\_\_\_\_
- (c) Describe the accident and how it happened \_\_\_\_\_
- \_\_\_\_\_
- (d) Names and addresses of witnesses to the accident \_\_\_\_\_
- \_\_\_\_\_

25. Have you, at any time before or after this disabling condition, had any injury, illness, disease or other problem that affects your ability to perform the duties of your job classification? ☐ Yes ☐ No If "Yes," list by date, doctor and hospital.

PROBLEM

DATE

NAME OF DOCTOR

NAME OF HOSPITAL

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

26. Do you consent to release to the panel of Hearing Examiners all medical records pertaining to both off-duty and line-of-duty accidents or illnesses you may have suffered at any time in the past, in accordance with the provisions of Maryland Code, Health-General Article §§ 4-301 *et seq.* and Subtitle E of 45 CFR 160? ☐ Yes ☐ No

NOTICE: Your eligibility for Line-of-Duty Disability Retirement will be determined at a hearing to be conducted by a Hearing Examiner in accordance with Article 22 of the Baltimore City Code. It will be in the nature of an adversary proceeding with testimony taken under oath. You, the Claimant, have the burden of proving, by the preponderance of the evidence, that you are permanently and totally disabled from the further performance of the duties of your job classification, and that your disability is the result of an accident while you were on duty, at a definite time and place, without willful negligence on your part. If you are a Class C or Class D member of the Retirement System, you must also prove that the incapacity resulting from the accident meets the requirements of section 9(j)(5) or section 9.2(i)(5) of Article 22 of the Baltimore City Code, respectively, relating to the degree of qualifying impairments.

27. **YOU HAVE THE RIGHT TO BE REPRESENTED BY COUNSEL OF YOUR CHOICE.** Will you be represented by counsel? ☐ Yes ☐ No If "Yes," give name, address and telephone number of your attorney:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I do solemnly declare and affirm under the penalties of perjury that the contents of this application are true and correct to the best of my knowledge, information and belief.**

SIGNATURE OF CLAIMANT \_\_\_\_\_

DATE \_\_\_\_\_

# OATH

STATE OF MARYLAND, COUNTY/CITY OF \_\_\_\_\_

I hereby certify that on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, personally appeared before me \_\_\_\_\_ and made oath in due form of law that the matters and facts stated in the foregoing document are true as therein set forth.

MY COMMISSION EXPIRES \_\_\_\_\_

NOTARY PUBLIC \_\_\_\_\_

[Seal]

## APPENDIX 1: MEDICAL RECORDS DISCLOSURE AUTHORIZATION

\_\_\_\_\_  
NAME OF HEALTH CARE PROVIDER OR MEDICAL FACILITY

THIS AUTHORIZATION IS FOR ANY RECORDS COVERING THE TIME PERIOD:

\_\_\_\_\_ to \_\_\_\_\_

I, the undersigned, for the purpose of processing my disability application, hereby authorize all medical sources, including, but not limited to, the above-named health care provider/medical facility, any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf, to disclose any or all of my protected health information, including, but not limited to, **any or all of my patient file, any or all medical records, radiology films/imaging**, and any or all protected health information, patient file, medical records, radiology films/imaging received from other health care providers to the Employees' and Elected Officials' Retirement Systems of the City of Baltimore ("Retirement Systems"). I understand that this protected health information may contain information pertaining to psychiatric, drug, alcohol, and HIV/AIDS diagnosis and treatment. I understand that the information disclosed pursuant to this authorization will no longer be protected by the Health Insurance Portability and Accountability Act. I understand that the health care provider/medical facility does not condition any treatment that I am otherwise entitled to receive on my signing this authorization. I understand that this authorization, except for action already taken, may be canceled by me at any time in writing to the Retirement Systems. I understand that my Application for Non-Line-of-Duty Disability Retirement will cease to be processed should I cancel this authorization.

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF MY SIGNATURE BELOW.

\_\_\_\_\_  
SIGNATURE OF CLAIMANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF CLAIMANT

\_\_\_\_\_  
DATE OF BIRTH OF CLAIMANT

\_\_\_\_\_  
SOCIAL SECURITY NO. OF CLAIMANT

If the Claimant is not able to consent to the release of the information:

\_\_\_\_\_  
SIGNATURE OF PERSON  
AUTHORIZED TO GIVE CONSENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
AUTHORITY

## APPENDIX 2: MEDICAL AND EMPLOYMENT RECORDS DISCLOSURE AUTHORIZATION

I, the undersigned, for the purpose of processing my disability application, hereby authorize the Retirement Systems to disclose any information received by the Employees' and Elected Officials' Retirement Systems ("Retirement Systems") pursuant to Appendix 1: Medical Records Disclosure Authorization, Form 25, Independent Medical Exams, Functional Capacity Exams, and the decision of the hearing examiner to my lawyer, the hearing examiner, the City of Baltimore and its agents and representatives, including, but not limited to, any department of the City of Baltimore, Key Risk (or any successor third-party Workers' Compensation administrator of the City of Baltimore), and the Office of the Inspector General, and any relevant law enforcement agency.

I authorize the City of Baltimore and its agents and representatives, including, but not limited to, any department of the City of Baltimore, Key Risk, and the Office of the Inspector General to disclose to the Retirement Systems any and all information in connection with the Retirement Systems' determination of my disability, including, but not limited to, medical records, personnel records, disciplinary records, and physical fitness exams. I hereby designate the Retirement Systems as my designee to receive that personnel information.

I authorize any employer with which I have submitted an application for employment after the date of the disability listed in this application for Line-of-Duty Disability Retirement to disclose to the Retirement Systems personnel records and medical records relating to my employment, including, but not limited to, my completed application, a description of the duties of the position for which I applied, statements of medical history completed as part of the application process, and physical exam or fitness test reports. I hereby designate the Retirement Systems as my designee to receive that personnel information. I authorize the Retirement Systems to disclose to any such employer any and all information described in this Medical and Employment Records Disclosure Authorization.

I understand that if judicial review of the decision of the hearing examiner is sought by me or the Retirement Systems, all of the information submitted into the record at the disability hearing, including, but not limited to, information received pursuant to this and any other authorization signed by me, as well as the decision of the hearing examiner, must be disclosed to the courts and any individuals involved in the judicial and appeal process, and therefore may be a matter of public record pursuant to judicial procedure. I authorize such disclosure.

\_\_\_\_\_  
SIGNATURE OF CLAIMANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF CLAIMANT

\_\_\_\_\_  
DATE OF BIRTH OF CLAIMANT

\_\_\_\_\_  
SOCIAL SECURITY NUMBER OF CLAIMANT

If the Claimant is not able to consent to the release of this information:

\_\_\_\_\_  
SIGNATURE OF PERSON  
AUTHORIZED TO GIVE CONSENT

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
AUTHORITY

CLAIMANT NAME \_\_\_\_\_ SSN \_\_\_\_\_ ]

**Authorization for Disclosure of Protected Health Information (PHI)**\_\_\_\_\_  
Specific Provider or Medical Facility (List all requested providers and facilities)

Patient Last Name	Patient First Name	Patient Middle Initial
Social Security Number	Date of Birth	Medical Record Number
Street Address	City	State/Zip Code
Home Phone Number	Work Phone Number	Mobile Phone Number

I, the undersigned, hereby authorize the above named provider or medical facility to disclose in writing to the individual, entity, facility, or company named below my PHI contained in my medical record. I further authorize the above named provider or medical facility to disclose my PHI electronically and/or discuss my PHI verbally with the individual, entity, facility, or company named below. I hereby authorize the disclosed PHI to include (check ALL that apply):

<input type="checkbox"/>	Bills	<input type="checkbox"/>	Nurse's Notes
<input type="checkbox"/>	Claims	<input type="checkbox"/>	Operative Reports
<input type="checkbox"/>	EKG/Catheterization Reports	<input type="checkbox"/>	Physician Orders
<input type="checkbox"/>	Emergency Room Records	<input type="checkbox"/>	Progress Notes
<input type="checkbox"/>	Hospital Discharge Summary	<input type="checkbox"/>	Radiology Films/Imaging
<input type="checkbox"/>	History and Physical	<input type="checkbox"/>	Radiology Reports
<input type="checkbox"/>	Laboratory Reports	<input type="checkbox"/>	ANY AND ALL RECORDS

Please release records covering the time period  
(MM/DD/YYYY to MM/DD/YYYY):

to \_\_\_\_\_

**Information to be disclosed to:**

(Name and address of the individual,  
entity, facility, or company to receive  
my PHI)

**Purpose of disclosure:**

The PHI provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including (HIV/AIDS) and/or genetic marker information.

I understand and agree to the following:

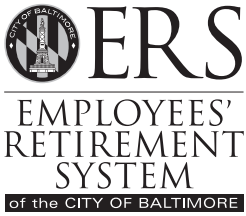
- Mercy Health Services does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization will expire one (1) year after the date of my signature below unless a shorter time period is stated here \_\_\_\_\_. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation.

\_\_\_\_\_  
Signature of Patient (or Legally Appointed Representative)\_\_\_\_\_  
Date\_\_\_\_\_  
Printed name of Legally Appointed Representative (if applicable)**Documentation establishing authority of Legally Appointed Representative**

(Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)

F056813 (12/10)

CLAIMANT NAME \_\_\_\_\_ SSN \_\_\_\_\_



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**ACKNOWLEDGEMENT  
REEMPLOYMENT AFTER RETIREMENT**

I understand that if I am reemployed by the City of Baltimore, my retirement benefits will be terminated. I will be required to repay any and all retirement benefits received while reemployed, in accordance with Baltimore City Code, Article 22, sections 9(n) and 9.2(l). If I return to work as a contractual employee, I understand that:

- I am subject to an earnings limitation in accordance with City policy.
- The term of my contract must not exceed 1 year and 1200 paid hours per year.
- There must be a minimum of 90 calendar days between my last day on City payroll and the start date of my contract.

See Administrative Manual 212-1. I agree to notify the Board of Trustees of the Employees' and Elected Officials' Retirement Systems if I return to City employment.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Applicant

State of Maryland  
City of Baltimore

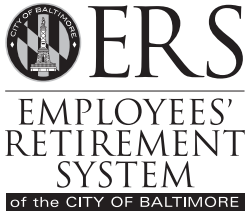
On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me, the undersigned officer, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

\_\_\_\_\_  
Signature [Seal]

\_\_\_\_\_  
Date





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## **ACKNOWLEDGEMENT WORKERS' COMPENSATION OFFSET**

I understand that **my disability benefit will be reduced** to offset the full amount of any past **workers' compensation award made within the 5 years** previous to the date of the accident or the date of the award, if the workers' compensation award is based on the **same disability** as my disability retirement from the Employees' and Elected Officials' Retirement Systems, as provided by the Baltimore City Code, Article 22, sections 9(o-4), 9.2(o), and 22(h). I understand that if I receive a workers' compensation award for the same disability as my disability retirement, my workers' compensation award may be offset.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Applicant

State of Maryland  
City of Baltimore

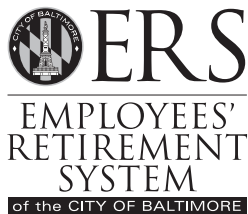
On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me, the undersigned officer, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
[Seal]

\_\_\_\_\_  
Date



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**ACKNOWLEDGEMENT**  
**ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY**

I understand that I am responsible for having **my doctor** complete the **Attending Physician's Statement of Disability**. I agree to return this document to the office of the Employees' and Elected Officials' Retirement Systems within **30 days** of my signature below. I understand that **if I do not return this document, my application for disability will not be considered.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Applicant

State of Maryland  
City of Baltimore

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me, the undersigned officer, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
[Seal]

\_\_\_\_\_  
Date

CLAIMANT NAME \_\_\_\_\_ SSN \_\_\_\_\_ ]

**ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY**

TO: Panel of Hearing Examiners  
Retirement Systems of the City of Baltimore

FROM: \_\_\_\_\_ M.D.  
ATTENDING PHYSICIAN

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Pension No.

\_\_\_\_\_  
Social Security No.

**REQUEST TO PHYSICIAN:** The purpose of this report is to assist in making a disability determination. Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to help in determining the severity and duration of the disability. If you wish, you may provide this information to us in narrative form.

1. **HISTORY:**

(a) When did symptoms first appear or accident happen? Month \_\_\_\_\_ Day \_\_\_\_\_ 20\_\_\_\_

(b) Date patient ceased work because of disability. Month \_\_\_\_\_ Day \_\_\_\_\_ 20\_\_\_\_

(c) Has patient ever had same or similar condition? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, state when and describe)

(d) Names and addresses of other consulting physicians (attach additional sheet if necessary) \_\_\_\_\_

2. **DIAGNOSIS:** (Including any complications)

**PRIMARY**

**SECONDARY**

(a) \_\_\_\_\_

(b) \_\_\_\_\_

(c) \_\_\_\_\_

(1) Subjective Symptoms or Patient's complaints: \_\_\_\_\_

3. **OBJECTIVE DATA:** (Including physical findings, laboratory data, EKGs, X-rays, or any other special tests.)

(a) \_\_\_\_\_

(b) \_\_\_\_\_

(c) \_\_\_\_\_

4. **DATES OF TREATMENT:**

(a) Date you first examined Month \_\_\_\_\_ Day \_\_\_\_\_ 20\_\_\_\_

(b) Date of last visit Month \_\_\_\_\_ Day \_\_\_\_\_ 20\_\_\_\_

(c) Frequency of visit Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Other (*specify*) \_\_\_\_\_

5. *NATURE OF TREATMENT AND RESPONSE:* (If any surgery, please enclose operative report)

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6. *PRESENT CONDITION AND PROGNOSIS:*

(a) Is this patient physically incapacitated? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, why? \_\_\_\_\_

(b) Is the patient mentally incapacitated? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, why? \_\_\_\_\_

(c) Is such incapacity likely to be permanent? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, why? \_\_\_\_\_

7. *EFFECT OF PHYSICAL OR MENTAL IMPAIRMENT ON DUTIES OF JOB:*

Please describe in detail the patient's physical or mental limitations

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---

Percent of Disability \_\_\_\_\_ %

8. *CARDIAC:* (If applicable)

(a) Functional capacity \_\_\_\_\_ Class 1 (No limitation) \_\_\_\_\_ Class 2 (Slight limitation)  
(*American Heart Ass'n*) \_\_\_\_\_ Class 3 (Marked limitation) \_\_\_\_\_ Class 4 (Complete limitation)

(b) Blood Pressure \_\_\_\_\_  
Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ Date Recorded \_\_\_\_\_

9. *ANATOMICAL LOSSES OF USE CAUSED BY ACCIDENTS:* (If applicable) Please indicate the total percentage of anatomical loss (A.L.) and of this percentage, preexisting loss, if any (P.E.L.) of use of any of the following functions or body parts caused by an accident and the date of the accident (D/A) which caused the loss:

	% of <u>A.L.</u>	% of <u>P.E.L.</u>	<u>D/A</u>		% of <u>A.L.</u>	% of <u>P.E.L.</u>	<u>D/A</u>
1. Speech	_____	_____	_____	6. Central Nervous System	_____	_____	_____
2. Sight	_____	_____	_____	7. Arm	_____	_____	_____
3. Hearing	_____	_____	_____	8. Leg	_____	_____	_____
4. Neck	_____	_____	_____	9. Shoulder	_____	_____	_____
5. Back	_____	_____	_____	10. Vital Body Organ	_____	_____	_____

\_\_\_\_\_  
Date Name of Attending Physician (Print) & Degree Telephone

\_\_\_\_\_  
Street City, State & Zip Code

\_\_\_\_\_  
Signature