

**APPLICATION FOR DISABILITY RETIREMENT  
(FOR DEPARTMENT FILING ON BEHALF OF EMPLOYEE)**

(Please provide the requested information for the employee. Complete all pages. If more space is required, attach additional sheets of paper. Print in ink.)

Date: \_\_\_\_\_

Social Security No.: _____		
Name: _____	(First)	(Middle)
_____ (Last)		
Other names used during County employment: _____		
Address: _____		
_____ (Street, Apt. No.)		
_____ (City)	_____ (State/Prov.)	_____ (ZIP Code)
Home Phone No.: _____	Work Phone No.: _____	
Cell Phone No.: _____	Fax No.: _____	
Age: _____	Sex: _____	Birth Date: _____
Driver's License No.: _____		
Currently married or registered as a domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Date of Marriage/Registration: _____		
Spouse/Domestic Partner Name: _____		
Spouse/Domestic Partner Birth Date: _____		

Names and birth dates of children under 18 years of age:	
Name	Date of Birth
_____	_____
_____	_____
_____	_____

Position for which permanently incapacitated: _____	
Item No.: _____	Employee No.: _____
Department No.: _____	
Department Name: _____	Location: _____
Years of Service: _____	Last Date at Work: _____



**The appointing authority hereby applies for:**

- Service-connected Disability Retirement**    **Nonservice-connected Disability Retirement**  
 **Supplemental Disability Allowance**

Is there another position that he/she would be able to perform with the County that would not result in a loss of income to the employee?

Yes       No

 **Service-connected salary supplement**

Government Code Section 31725.65 allows retired members with service-connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower-paying County position, LACERA will pay the member a supplemental allowance totaling the difference between the new, lesser-paying position and the previous higher-paying position. **Applies only to those members who were incapacitated for the performance of their duties on or after January 1, 2004, and who are eligible for a service-connected disability retirement.\***

 **Nonservice-connected salary supplement**

Government Code Section 31725.5 allows retired members with nonservice-connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower-paying County position, LACERA will pay the member a supplemental allowance totaling the difference between the new, lesser-paying position and the previous higher-paying position. **Applies to members eligible for a nonservice-connected disability retirement.**

**NOTE:** If at the time of its initial determination, the Board of Retirement (BOR) finds an applicant is permanently incapacitated but the disability is not work-related, the BOR may grant a nonservice-connected disability retirement. The applicant **may appeal** that decision. **However, the BOR's finding of disability will not be binding if its initial determination is appealed and referred for an administrative hearing.**

**Current employment status with County (check all that apply):**

- Working \_\_\_\_\_ hours per week.  
 Sick leave with compensation. Approximate date leave ends: \_\_\_\_\_  
 Industrial leave with compensation. Approximate date leave ends: \_\_\_\_\_  
 Resigned or terminated from County service. Effective date: \_\_\_\_\_  
 Receiving or have received Long-Term Disability (LTD) benefits administered by the County of Los Angeles Third Party Administrator.  
 Period(s) paid by LTD? \_\_\_\_\_

\* Government Code 31725.6 applies to members who were incapacitated for the performance of their duties prior to January 1, 2004.



1. Describe specifically the injury or illness causing the employee to be permanently disabled from performing his/her duties including the body parts that are involved:

---

---

---

---

---

2. What date did the injury occur or when did you first notice the employee was ill? \_\_\_\_\_

3. Where did the injury or illness occur? \_\_\_\_\_

4. How did the injury occur, or what caused the onset of the illness? **(Please answer completely.)**

---

---

---

---

5. Please list all witnesses to the job-related injuries or illness. Give name, work locations, phone numbers, and addresses of the witnesses.

---

---

---

---

6. Describe **actual duties performed** by the employee at the time the disability arose. (Attach County Class Specification and Job Analysis, if applicable.)

---

---

---

---

---

---



7. State in detail the **usual duties the employee cannot perform** because of his/her disability.

---

---

---

---

---

---

---

---

8. Please list and date all attempts to accommodate the employee's disability, including interactive meetings, ergonomic studies, etc.

---

---

---

---

---

9. (a) Did the job or job environment aggravate or accelerate a preexisting injury or illness?

**Yes**     **No**    **If Yes:**

(b) What is the nature of the preexisting injury or illness?

---

---

---

---

---

(c) Give the date of the original occurrence of the injury or onset of the illness.

---

10. Does the employee have any permanent work restrictions?

**Yes**                       **No**                       **I Don't Know**

**If Yes, who issued the restrictions?**

\_\_\_\_\_ Occupational Health Services (OHS)

\_\_\_\_\_ Workers' Compensation

\_\_\_\_\_ Other

Please attach a copy of the work restrictions.



11. Include any information you wish the BOR to consider in determining the employee's disability.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Please list the name and telephone number of the employee's last supervisor.

Name: \_\_\_\_\_

Work Location: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

If this individual supervised the employee for less than one year, please list the name and telephone number of their prior supervisor.

Name: \_\_\_\_\_

Work Location: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

**I declare, under penalty of perjury, that to the best of my knowledge the foregoing is true and correct.**

Executed on \_\_\_\_\_ (Date) in \_\_\_\_\_ (City), California.

\_\_\_\_\_  
Authorized Employer Signature

\_\_\_\_\_  
Employer's Email Address

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone No.