DISABILITY APPLICATION & STATEMENT
(NOT IN THE LINE OF DUTY)

THIS SECTION TO BE COMPLETED BY EMPLOYEE DATE____________

Name of Employee	Social Security No.	Classification
Department	Home Address-City & State – Zip Code	Telephone No.

____ ________________________

Date Application Gave Up Employment Because of Disability (last date actually worked)

Date First Treated by Physician For this Disability

I hereby affirm that I am totally and permanently disabled to perform my regular, assigned, or comparable duties for the City of Atlanta, and such disability was either caused by or resulted from an accident or injury sustained on this job. The accident, injury, and medical condition upon which I base my application are as follows:

____

____

Regarding the above referenced injury(ies), did you receive medical attention? If so, state hospital and name of physician. ____

As a __________________ for the City of Atlanta my regular assigned duties are as
Classification
follows: ____

Have you received treatment, attention, or advice from any physician or other practitioner for, or been told by any physician or other practitioner that you have or have ever had:

- High blood pressure, chest pain, or heart trouble? ____ Yes ____ No
- Asthma, bronchitis, tuberculosis, or other disease or the lungs? ____ Yes ____ No
- Gallstone , ulcers, or any disease of the liver? ____ Yes ____ No
- Epilepsy, paralysis, dizziness, or any mental or nervous disorder? ____ Yes ____ No
- Cancer or other tumor? ____ Yes ____ No
- Arthritis or rheumatic fever, back or joint/injury? ____ Yes ____ No
- Diabetes; disease of the kidneys? ____ Yes ____ No
- Anemia, leukemia, or disease of the blood? ____ Yes ____ No
- Any deformity, loss or impairment of limb, sight, or hearing? ____ Yes ____ No

List below all illness or injuries suffered during the past five (5) years, provide the dates of treatment, names of physicians or practitioners involved, during of treatment, and any other relevant information. (If more space is needed, attach sheet).