

FPDR



January 2013

Bureau of Fire and Police Disability and Retirement

1800 SW First Avenue, Suite 250, Portland, OR 97201
503-823-6823; FAX – 503-823-5166; B236/250



NON SERVICE-CONNECTED DISABILITY REPORT

(For Injury/Illnesses Not in the Line of Duty)

MEMBER INFORMATION SUPERVISOR

Member's Legal Name:

Residence Address:
(include city and zip code)

e-mail address: _____

Fire Station

Police Precinct/Shift/Scheduled Days off:

Telephone: (home) _____

(mobile) _____ **(work)** _____

OUTSIDE EMPLOYMENT

Do you have employment outside of the Fire/Police Bureau? YES NO

Do you own or intend to own a business? YES NO

(If Yes, you must complete "Report of Earnings form")

INJURY/ILLNESS TIME LOSS DATES

Date of Current Injury/Illness: _____

Dates off duty: 1st Day off Work: _____
(WSR is Required)

Return to Work: _____

Related to Prior Injury/Illness? Yes No
If yes, date of original injury/illness: _____

MEDICAL PROVIDER INFORMATION (If known)

Name of Attending Physician: _____

Physician's Address: _____

(include city, state & zip code) _____

Physician's Telephone: _____

Name of Hospital, if any: _____

INJURY/ILLNESS DESCRIPTION (If injury/illness has resulted in member's death, please contact FPDR for a "Death Claim Report" form.)

Describe Injury or Illness (body part/condition):

APPLICANT'S STATEMENT: I hereby affirm the above information is true and hereby apply for disability benefits. By signing and submitting this form, I agree and **authorize medical providers and other custodians of claim records to release relevant medical records.**

Signature _____ Date _____



Faxed

Supervisors: Do not wait for all bureau signatures before faxing form to FPDR (503-823-5166)

Immediate Supervisor (Name/Rank/Unit)

Date

RU commander/Battalion Chief

Date

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY