EXPLANATION OF DISABILITY

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 804-786-9718
www.varetire.org

Clear Form

1. Social Security Number
2. Name

3. **Address** (Street, City, State and ZIP+4)		
4. **Phone Number**	5. **Date of Birth** (mm/dd/yy)	
6. **Employer**	7. **Job Title**	
8. **Dates of Employment** Initial hire date _____ Date you began this job _____	9. **Are you still working?** ❑ No - Enter date last worked _____ ❑ Yes - Employer must complete Form VRS-6D	10. **Date leave without pay began** (mm/dd/yy)
11. **Supervisor Name and Phone Number**		

Very careful consideration should be given to the following section of your application. Fully describe the medical problem so that we can understand why you feel unable to continue your job.

12. **In your own words, list all the job duties you are required to perform on a regular basis:**
13. **Which of your duties listed above can you NOT perform?**
14. **What illness or injury prevents you from working?**
15. **Number of days lost from work during last year due to this disability:** _____ Explain:
16. **In what way(s) has your doctor told you to restrict your activities?**
17. **Are your home duties, school activities or abilities to care for your personal needs limited in any way?** ❑ No ❑ Yes If yes, please explain:

18. SSN

19. Have you ever been treated at a hospital or clinic for your disability? ❑ No ❑ Yes

Were you admitted to a hospital? ❑ No ❑ Yes (If yes, attach discharge summary)

List the name, addresses, dates and reasons for hospitalizations or clinic visits and the types of treatment received concerning your disability so that records may be obtained if VRS needs them.

(Name of Hospital)	(Address)	(Dates)	(Reason)

Name of physician treating disability	**Physician's Phone Number**

Physician's Address (Street, City, State and ZIP+4)

Date you first saw physician	**Date you last saw physician**	**How often do you see the physician?**

20. List the names and address of any other physicians that you have seen in the past year related to your disability:

(Name)	(Address)	(Reason for Visit)

Certification

I hereby certify that all information I have given in this document is true and understand that any willful falsification of facts presented may result in a denial of my application for disability retirement and prosecution for a Class 1 misdemeanor as provided by law. I authorize any physician, agency or other organization to disclose any medical records or other information regarding my disability to the Board of Trustees and the Medical Review Board of the Virginia Retirement System. I also hereby authorize VRS to disclose any medical records or other information regarding my disability to any physician, agency or organization as may be required for my disability determination.

Member Signature _____ Date _____