



Pension Board

917B E. Fifth Ave.
Knoxville, TN 37917
www.knoxvillepensionboard.org

APPLICATION FOR DISABILITY PENSION

Please use additional pages as necessary to completely answer each question.

PART 1: PERSONAL INFORMATION

Name: _____ Employee ID: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Telephone: _____

Email Addresses: _____

Department: _____ Hire Date: _____

Job Title: _____

Name of Supervisor/Section Chief: _____

Supervisor's Phone number: _____

In your own words, describe the treatment you have received and identify the physician or medical provider providing the treatment:

List all medications you are taking, including over-the-counter medications and indicate which physician prescribed each of them:

Have you been released from treatment? Yes No

If yes, when? _____

Have you been released to return to work? Yes No

If yes, do you have any restrictions? Yes No

Please Describe: _____

If no, do you expect to be released to return to work? Yes No

Why or why not? _____

Is your illness/injury expected to improve? Yes No

Why or why not? _____

Have you received a disability rating from any medical provider? Yes No

If yes, describe your disability rating: _____

In your own words, describe in as much detail as possible how your illness/injury affects your ability to do your job:

Are you receiving or have you received any other disability benefit from any source for the same illness/injury? Yes No

If yes, what source? _____

Please provide correspondence listing the award and any adjustments to your award.

Have you applied for Social Security Disability benefits? Yes No

If yes, what is the status of your application? _____

PART III: IN LINE OF DUTY DISABILITY (If you are not applying for an In Line of Duty Disability Pension, please skip to Part IV)

Were you injured on the job? Yes No

Did you report the injury to your supervisor? Yes No

Did you complete an incident report? Yes No

Did you seek immediate medical attention? Yes No

If yes, where did you go and who did you see? _____

If no, please explain why, as well as where and when you first sought treatment:

In your own words, describe in as much detail as possible how you were injured, including where you were and what you were doing at the time of your injury:

Did you make a claim for worker's compensation? Yes No

If yes, are receiving benefits or was a settlement reached? Yes No

Were you denied benefits? Yes No

Have you reached maximum medical improvement? Yes No

Have you been approved to return to work without restrictions? Yes No

Have you been approved to return to work with restrictions? Yes No

If yes, describe restrictions: _____

Have you ever been previously treated for the same illness or an injury to the same body part?

Yes No

If yes, please describe prior illness/injury, including date of illness/injury, medical providers seen, and treatment received:

PART IV: MEDICAL RECORDS

Attach all medical records for all treatment sought and received for the illness/injury described above.

This application is not complete and will not be accepted for processing unless all medical records are attached. If you submit this application without the medical records attached, it will be returned to you for completion.

I CERTIFY THAT ALL STATEMENTS AND INFORMATION PROVIDED HEREIN ARE TRUE AND ACCURATE.

Signature: _____

Date: _____

RECEIVED AND ACKNOWLEDGED BY THE PENSION BOARD:
DATE: _____ **BY:** _____