



# Pension Board

917B E. Fifth Ave.  
Knoxville, TN 37917  
www.cokpension.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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



---

---

---

---

---

---

---

**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:** \_\_\_\_\_