DES PLAINES FIREFIGHTERS' PENSION FUND
APPLICATION FOR TERMINATION OF DISABILITY BENEFITS

Name: ____ Rank: ___________________________

DOB: _______________ Date of appointment ________________ , __________.

Member of the Fire Department for ___________ year(s), _____________ month(s)

Date of original receipt of disability pension from the Fund: ______________________________

Date of application for termination of disability pension: ________________________________

The nature of my current disability pension is (please check one):

_______ Line of Duty (40 ILCS 5/4-110)

_______ Not in the Line of Duty (40 ILCS 5/4-111)

_______Occupational Disease (40 ILCS 5/4-110.1)

I have been examined by the following physicians in regards to this disability:

NAME ADDRESS/PHONE EXAMINATION DATE

____

____

____

(Please use a separate sheet if additional space is needed.)

Have you had a recent functional capacity evaluation? Yes [ ] No [ ] If yes, please list the name of the facility where you were tested and the date of the evaluation.

FACILITY ADDRESS/PHONE EVALUATION DATE

____

____

I also hereby consent to the release of the following to the Board of Trustees of the Des Plaines Firefighters' Pension Fund and its attorneys: (1) any and all medical records prepared during the physical examination I was required to undergo for employment with the Des Plaines Fire Department or application with the Des Plaines Firefighters' Pension Fund; (2) any examination by the physician(s) or physical therapists I listed above; (3) any medical test results and any examination by any physician or physical therapist which is relevant to the application I am making; (4) any relevant employment records from the Des Plaines Fire Department or any employer I have listed above; and (5) any other additional relevant records from any source that may be relevant to this application. A photocopy of the authorization shall be as effective and valid as the original.

I also understand that I must complete and sign an authorization for release of health information which is attached to this application.

____
Signature of Petitioner

____
Address

____
Phone Number

____
City, State, and Zip Code

____
Social Security Number

____
Date

FOR BOARD USE ONLY

Received by ____________________________________ **on** ________________________________
(date)

____
Signature

The foregoing application for termination of a disability pension having been duly presented and considered by the Board of Trustees of the Des Plaines Firefighters' Pension Fund, the same is hereby Approved/Rejected (circle one) this ________day of ______________, ______.

BOARD OF TRUSTEES OF THE
DES PLAINES FIREFIGHTERS' PENSION FUND

By: ____
President

By: ____
Secretary