**POLICE AND FIREFIGHTERS RETIREMENT AND RELIEF BOARD**

**District of Columbia Government**

**DISABILITY HEARING FORM**

**TIERS TWO and THREE**

|  |
| --- |
| **SECTION A** |

***Instructions: Answer all questions. If not applicable, indicate with N/A***

|  |  |  |
| --- | --- | --- |
| **NAME (First, Middle, Last)** | **DATE OF BIRTH** | **AGE** |
| **CURRENT ADDRESS** |
| **CITY/STATE/ZIP CODE** |
| **HOME PHONE NUMBER** | **WORK PHONE NUMBER** | **CELLULAR PHONE NUMBER** |
| **APPOINTMENT DATE** | **SOCIAL SECURITY NUMBER (LAST 4 DIGITS)** |
| **SUPERVISOR’S NAME** | **DEPARTMENT/UNIT** |
| **LOCATION** |
| **RANK/CLASS/GRADE** | **BASE SALARY ONLY** |
| **LIST PREVIOUS****GOVERNMENT****SERVICE** | **AGENCY** | **DATE OF SERVICE** |
|  |  |
|  |  |
|  |  |
|  |  |
| **ATTORNEY’S NAME (First, Last)** |
| **MAILING ADDRESS**  | **SUITE/ROOM NUMBER** |
| **CITY/STATE/ZIP CODE** |
| **OFFICE PHONE NUMBER** | **FAX NUMBER** | **CELLUAR PHONE NUMBER** |

|  |
| --- |
| **SECTION B** |

|  |
| --- |
| **HAVE YOUR MEDICAL RECORDS EVER BEEN REVIEWED BY THE BOARD FOR DISABILITY RETIREMENT? YES NO** |
| **IF YES, WHEN?** | **WHAT WAS THE OUTCOME?** |
| **WHAT IS YOUR CURRENT DUTY STATUS? (check all that apply) BEGINNING DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **FULL DUTY LIMITED DUTY SICK LEAVE ANNUAL LEAVE SUSPENSION**  **ADMINISTRATIVE LEAVE LEAVE WITHOUT PAY** |
| **IF YOUR CURRENT DUTY STATUS IS LIMITED DUTY, WHAT DUTIES ARE YOU CURRENTLY PERFORMING?** |
| **WAS THIS DUTY STATUS THE RESULT OF ANY INJURY OR DISEASE? YES NO** |
| **IF YES, WHAT DATE DID THE INJURY OR DISEASE OCCUR?** |
| **LIST ALL PERIODS OF LEAVE IN A NON-PAY STATUS (LWOP, AWOL, etc.)** | **DATE** | **TYPE** | **NUMBER OF DAYS** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **DO YOU WISH TO RETURN TO FULL DUTY AT SOME DATE? YES NO** |
| **IF NO, EXPLAIN WHY** |
| **IF A MEMBER OF MPD, DO YOU CURRENTLY HAVE YOUR POLICE POWERS? YES NO** |
| **HAVE YOUR POLICE POWERS BEEN REVOKED? YES NO** |

|  |
| --- |
| **SECTION C** |

|  |
| --- |
| **ARE YOU REQUESTING DISABILITY RETIREMENT? YES NO** |
| **WHAT IS THE DATE OF THE INJURY? (IF APPLICABLE)** |
| **IN WHAT CATEGORY?**  **On Duty**  **On Duty, But Not In The Performance Of Duty**  **On Duty, But Condition Aggravated by Performance of Duty**  **Off Duty**  |
| **DO YOU AGREE WITH THE CLINIC’S ASSESSMENT OF THE DIAGNOSIS OF YOUR CONDITION? YES NO** |
| **IF NO, EXPLAIN** |
| **SECTION D** |

|  |  |
| --- | --- |
| **WHAT IS YOUR CURRENT WEIGHT?** | **WHAT IS YOUR HEIGHT?** |
| **HAVE YOU EVER HAD ACUPUNCTURE? YES NO** |
| **IF YES, WHERE AND FOR WHAT CONDITIONS?** |
| **HAVE YOU EVER BEEN SEEN BY A CHIROPRACTOR? YES NO** |
| **IF YES, GIVE LOCATION WHERE TREATMENT WAS PROVIDED** |
| **WHAT CONDITION WAS TREATED BY CHIROPRACTOR?** |
| **ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? YES NO** |
| **NAME OF TREATING PHYSICIAN** |
| **ADDRESS OF TREATING PHYSICIAN** | **TELEPHONE NUMBER OF TREATING PHYSICIAN** |
| **WHAT CONDITION IS BEING TREATED? (list all conditions being treated)** |
|  |
|  |
|  |
| **HAVE YOU EVER BEEN HOSPITALIZED FOR ANY REASON SINCE YOUR INJURY OR ILLNESS?** **YES NO** |
| **IF YES, WHERE?**  | **WHAT WAS THE CONDITION?** |
| **HAVE YOU HAD ANY EMERGENCY ROOM VISITS? YES NO** |
| **IF YES, WHAT WAS THE CONDITION** | **DATE** | **TREATMENT PROVIDED** |
| **HAVE YOU BEEN TREATED FOR ANY MEDICAL CONDITION BY A PHYSICIAN OR THERAPIST SINCE YOUR INJURY OR ILLNESS? YES NO** |
| **IF YES, WHERE?** | **WHAT WAS THE CONDITION?** |
| **WHEN WAS TREATMENT PROVIDED?** |
| **HAVE YOU BEEN IN ANY ACCIDENTS SINCE YOUR INJURY? YES NO**  **Motor Vehicle Accidents Slip and Falls Sports or Other Physical Activity Injuries**  **Lifting Throwing Injuries**  |
| **HAVE YOU BEEN INVOLVED IN ANY PHYSICAL CONFRONTATIONS (Pushing and Shoving)** **FIGHTS OR ASSAULTS?**  **YES NO** |
| **DID ANY OF THESE ACCIDENTS REQUIRE MEDICAL TREATMENT YES NO** |

|  |
| --- |
| **SECTION D - CONTINUED** |

|  |
| --- |
| **LIST EACH INJURY/ACCIDENT** |
| **NATURE OF INJURY OR ACCIDENT** | **DATE OF INJURY OR ACCIDENT**  | **LOCATION OF TREATMENT** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **HAVE YOU HAD SURGERY TO ANY OTHER PART OF YOUR BODY SINCE YOUR INJURY?**  **YES NO** |
| **IF YES, LIST THE PARTS OF THE BODY OPERATED ON, THE TYPE OF OPERATION PERFORMED, THE DATE OF THE OPERATION, AND THE NAME OF THE HOSPITAL.** |

|  |  |
| --- | --- |
| **PART OF THE BODY TYPE OF SURGERY** | **DATE OF SURGERY NAME OF HOSPITAL** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **SECTION D - CONTINUED** |

|  |
| --- |
| **LIST ALL X-RAYS, MRI(S) PERFORMED. LIST THE PARTS OF THE BODY STUDIED, AND THE DATES FOR EACH OCCURRENCE** |

|  |
| --- |
|  **MRI X-RAY** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |
|  **MRI X-RAY** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |
|  **MRI X-RAY** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |

|  |
| --- |
| **SECTION D - CONTINUED** |

|  |
| --- |
| **LIST ALL EMG (S) AND NERVE CONDUCTION STUDIES PERFORMED. LIST THE PARTS OF THE BODY STUDIED AND THE DATES FOR EACH OCCURRENCE.**  |

|  |
| --- |
|  **EMG NERVE CONDUCTION** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |
|  **EMG NERVE CONDUCTION** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |
|  **EMG NERVE CONDUCTION** **DATE OF OCCURRENCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****BODY PART(S) STUDIED:**  |

|  |
| --- |
| **SECTION D - CONTINUED** |

|  |
| --- |
| **LIST ALL MEDICATIONS CURRENTLY USED** |

|  |
| --- |
| **NAME OF FREQUENCY OF NAME OF PRESCRIBING****MEDICATION DOSAGE USE PHYSICIAN** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **SECTION E** |

|  |
| --- |
| **DO YOU, YOUR SPOUSE, OR REGISTERED DOMESTIC PARTNER CURRENTLY OWN OR OPERATE A BUSINESS? YES NO**  |
| **IF YES, WHAT TYPE OF BUSINESS DO YOU OWN OR OPERATE?**  |
| **IF YES, HOW MANY HOURS DO YOU WORK?** |
| **WHAT IS THE NAME OF THE BUSINESS?** |
| **WHAT IS THE REGISTERED NAME OF THE BUSINESS?** |
| **WHAT IS THE ADDRESS OF THE BUSINESS?** |
| **HOW LONG HAS THE BUSINESS EXISTED?** |
| **ARE YOU CURRENTLY PERFORMING ANY OUTSIDE EMPLOYMENT THAT IS NOT ASSOCIATED WITH A BUSINESS YOU OWN OR OPERATE? YES NO** |

|  |
| --- |
| **SECTION F** **EDUCATIONAL HISTORY** |

|  |
| --- |
| **NAME OF HIGH SCHOOL** |
| **CITY/STATE OF SCHOOL** |
| **HIGHEST GRADE COMPLETED** |
| **COURSE OF STUDY**  | **DATE OF GRADUATION** |  **DIPLOMA GED** |

|  |
| --- |
| **SECTION F – CONTINUED** |

**UNDERGRADUATE STUDIES**

|  |
| --- |
| **NAME OF SCHOOL** |
| **CITY/STATE** |
| **DATE(S) OF ATTENDANCE** |
| **COURSE OF STUDY** |
| **HIGHEST LEVEL COMPLETED** **FRESHMAN JUNIOR SOPHMORE SENIOR NOT APPLICABLE** |
| **EXPECTED DATE OF GRADUATION** |
| **TYPE OF DEGREE AWARDED** |

|  |
| --- |
| **LIST MAJOR COURSES OF STUDY** |

|  |  |  |  |
| --- | --- | --- | --- |
| **SUBJECT** | **HOURS** | **SUBJECT** | **HOURS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**GRADUATE STUDIES**

|  |
| --- |
| **NAME OF SCHOOL** |
| **CITY/STATE** |
| **DATE(S) OF ATTENDANCE** |
| **COURSE OF STUDY** |
| **EXPECTED DATE OF GRADUATION** |
| **TYPE OF DEGREE AWARDED** |

|  |
| --- |
| **LIST MAJOR COURSES OF STUDY** |

|  |  |  |  |
| --- | --- | --- | --- |
| **SUBJECT** | **HOURS** | **SUBJECT** | **HOURS** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **SECTION F - CONTINUED** |

|  |
| --- |
| **LIST OTHER JOB OR VOCATIONAL TRAINING** |

|  |  |
| --- | --- |
| **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** | **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** |
| **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** | **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** |
| **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** | **TITLE OF JOB OR VOCATIONAL TRAINING:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Certificate of Completion**  **Certification Issued** **License Issued** **N/A** |

**SECTION G**

**MILITARY HISTORY**

|  |
| --- |
| **BRANCH OF SERVICE**  |
| **DATES OF SERVICE** |
| **HIGHEST RANK ACHIEVED** |
| **TYPE OF DISCHARGE** **Honorable General/Medical (under honorable conditions) Other than Honorable Bad Conduct**  **Dishonorable**  |
| **WHAT WAS YOUR OCCUPATION DURING YOUR MILITARY SERVICE?** |
| **PROVIDE A DESCRIPTION OF YOUR DUTIES** |
| **SECTION H****WORK HISTORY** |

|  |
| --- |
| **STARTING WITH YOUR LAST POSITION, LIST ALL JOB HELD SINCE HIGH SCHOOL. ATTACH A COPY OF YOUR CURRENT JOB DESCRIPTION AND RESUME, IF AVAILABLE.** |

|  |  |
| --- | --- |
| **POSITION TITLE** | **DATES OF EMPLOYMENT** |
| **EMPLOYER’S NAME** |
| **WORK ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **WHAT SPECIAL TRAINING DID YOU RECEIVE FOR THIS POSITION? N/A** |
| **DESCRIBE THE DUTIES OF THE POSITION** |
| **POSITION TITLE** | **DATES OF EMPLOYMENT** |
| **EMPLOYER’S NAME** |
| **WORK ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **WHAT SPECIAL TRAINING DID YOU RECEIVE FOR THIS POSITION? N/A** |
| **DESCRIBE THE DUTIES OF THE POSITION** |

|  |  |
| --- | --- |
| **POSITION TITLE** | **DATES OF EMPLOYMENT** |
| **EMPLOYER’S NAME** |
| **WORK ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **WHAT SPECIAL TRAINING DID YOU RECEIVE FOR THIS POSITION? N/A** |
| **DESCRIBE THE DUTIES OF THE POSITION** |

|  |  |
| --- | --- |
| **POSITION TITLE** | **DATES OF EMPLOYMENT** |
| **EMPLOYER’S NAME** |
| **WORK ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **WHAT SPECIAL TRAINING DID YOU RECEIVE FOR THIS POSITION? N/A** |
| **DESCRIBE THE DUTIES OF THE POSITION** |

|  |  |
| --- | --- |
| **POSITION TITLE** | **DATES OF EMPLOYMENT** |
| **EMPLOYER’S NAME** |
| **WORK ADDRESS** | **CITY** | **STATE** | **ZIP CODE** |
| **WHAT SPECIAL TRAINING DID YOU RECEIVE FOR THIS POSITION? N/A** |
| **DESCRIBE THE DUTIES OF THE POSITION** |
| **SECTION I****JOB SKILLS** |

|  |
| --- |
| **LIST THE SKILLS THAT YOU ACQUIRED IN YOUR POSITION AS A UNIFORMED MEMBER OF THE POLICE OR FIRE DEPARMENT** |

|  |
| --- |
| **SKILL #1** |
| **SKILL #2** |
| **SKILL #3** |
| **SKILL #4** |
| **SKILL #5** |

|  |
| --- |
| **CHECK THE TYPE OF OFFICE EQUIPMENT THAT YOU CAN OPERATE** **Facsimile machine Copier machine Adding machine Calculator Postage machine**  **Multi-Line Telephone Computer Cash Register Mail Distribution Other** |

|  |
| --- |
| **CHECK THE COMPUTER SOFTWARE PROGRAMS THAT YOU HAVE LITTLE OR SOME EXPERIENCE OPERATING** **Microsoft Word Microsoft Excel Microsoft Outlook Microsoft Power Point Windows**  |

|  |
| --- |
| **CHECK ANY JOB SKILLS OR TRAINING THAT YOU ACQUIRED IN HIGH SCHOOL OR AFTER HIGH SCHOOL** **Private Investigator Security Work Counseling Radio Dispatcher Desk/Office Clerk**  **Time and Attendance Clerk Public Speaking Sales Person Telephone Operator**  **Truck Driver Delivery Clerk Mail Courier Mail Distribution Collections Para Legal** **Legal Research Barber Hair Stylist Manicurist Seamstress/Tailor**  **Day Care Provider Musician Instructor/Teacher Construction Worker Dry Wall**  **Painter Bricklayer Mortician Therapist Cook Food Service Worker/Manager**  **Waitress/Waiter Bartender Other**  |

|  |
| --- |
| **SECTION J** |

|  |
| --- |
| **DO YOU HAVE A VALID DRIVER’S LICENSE? YES NO** **WHAT STATE?** |
| **DO YOU HAVE A VALID COMMERCIAL DRIVER’S LICENSE? YES NO****WHAT STATE?** |
| **WHAT TYPE OF VEHICLES ARE YOU LICENSED TO OPERATE?** |
| **DO YOU RIDE A BICYCLE? YES NO HOW OFTEN DO YOU RIDE?** |
| **DO YOU OPERATE A MOTORCYCLE? YES NO HOW OFTEN DO YOU RIDE?** |
| **LIST ANY OTHER MOTORIZED EQUIPMENT THAT YOU KNOW HOW TO OPERATE** |

|  |
| --- |
| **SECTION L** |

**I understand that a false statement on any part of my application may be grounds for denying my claim for survivor benefits. (D.C. Official Code § 1-615-51 et seq. 2001).I understand that the making of a false statement on this form or materials submitted with this form is punishable by criminal penalties pursuant to D.C. Official Code § 22-2405 et seq. (2001). I understand that any information I give may be investigated as allowed by law or Mayoral order. I consent to the release of information regarding my eligibility or the eligibility of any dependent children for survivor benefits to authorized employees, investigators, or retirement specialists of the District of Columbia government.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify that, to the best of my knowledge**

 **Print Name**

**and belief, all of my statements are true, correct and complete.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature of Applicant Date**

**SUBSCRIBED AND SWORN BEFORE ME THIS \_\_\_\_\_\_ DAY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Name of Notary Public**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature of Notary Public**

**STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MY COMMISSION EXPIRES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SEAL**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**POLICE AND FIREFIGHTERS RETIREMENT AND RELIEF BOARD**

**DISABILITY RETIREMENT PAYROLL DATA SHEET**

|  |  |
| --- | --- |
|  FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MIDDLE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL SECURITY NUMBER : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**E-MAIL ADDRESS** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  MARITAL STATUS: (√) one MARRIED: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DIVORCED: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEPARATED: Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOMESTIC PARTNERSHIP Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CERTIFIED DOMESTIC PARTNERSHIP TERMINATION STATEMENT  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SINGLE |
| MAILING ADDRESS | TELEPHONE NUMBER |
| CITY/STATE/ZIP CODE |  MALE FEMALE | DEPARTMENT/AGENCY |
| DATE OF BIRTH | AGE |  RETIREMENT TIER One (20 years) Two (25 years & Age 50) Three (25 years ) | DATE OF APPOINTMENT |
| SOCIAL SECURITY NUMBER FOR SPOUSE OR CERTIFIED DOMESTIC PARTNER | FULL NAME OF SPOUSE OF CERTIFIED DOMESTIC PARTNER. |  DATE OF BIRTH FOR SPOUSE OR CERTIFIED DOMESTIC PARTNER |

**1. If the Retirement Board should retire you, do you wish your annuity reduced by 10% to supplement your survivor’s benefits upon your death? (Public Law 96-122 as amended)**

**⁭**  **Yes ⁭**  **No**

**2. If you are divorced or have a Statement of Domestic Partnership Termination, will your annuity benefit be subject to distribution under the D.C. Spousal Equity Act of 1988, D.C. Code § 1-529.01**

**⁭**  **Yes**   **No**

**3. If you answered YES to question 2, do we currently have a Qualified Domestic Relations Order (QDRO) on file?**

**⁭**  **Yes**   **No**

**4. Are there any children currently listed on your health insurance? ⁭⁭**  **Yes**   **No**

**5. Are there any children that you provide at least 50% of their support? ⁭ ⁭**  **Yes**   **No**

**6. If you answered YES to questions 5 or 6, complete information below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME OF CHILD** **(First, Middle, Last)** | **DATE OF BIRTH** | **AGE** | **SOCIAL SECURITY NUMBER** | **If Child Is Over 18 Years Old Is He Or She:** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |
|  |  |  |  |  A **Student Self-Supporting** |