Rev. 01/13

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM

7722 OFFICE PARK BOULEVARD, SUITE 200
BATON ROUGE, LA 70809-7601
Telephone: (225) 929-7411 • Toll Free: (800) 443-4248 • Fax: (225) 929-6542
www.lampers.org

Municipality No.
To Be Completed By MPERS

MEMBER ENROLLMENT FORM

SECTION I. EMPLOYEE INFORMATION

INSTRUCTIONS: This application is designed for multipurpose use and for data input. Type or print in black ink all entries except signatures.

SOCIAL SECURITY #:

Name (Last, First, Middle Initial)

Mailing Address

MARITAL STATUS (Check One)

❑ Married ❑ Widow(er)
❑ Single Never married ❑ Divorced

City	State	Zip Code	Telephone No. Area Code ( )	Date of Birth	Mo	Day	Year	Sex ❑ M ❑ F

Must be under age 50 at date of employment. If over age 50, must have contributions on deposit in another Louisiana Public Retirement System.

Original Date of Employment at Police Dept.	Mo	Day	Year	MPERS Entry Date	Mo	Day	Year

SECTION II. PREVIOUS ENROLLMENT

A. If you were at any time a member of this system, give name under which your membership was reported and dates employed.

From (Mo./Yr.) | To (Mo./Yr.) | STATUS: ❑ Refunded ❑ Transfer ❑ Inactive

B. Are you now or have you ever been a member of another Louisiana Public Retirement System? If Yes, which one(s) (list): ❑ Yes ❑ No

From (Mo./Yr.) | To (Mo./Yr.)

WHAT IS YOUR PRESENT STATUS IN OTHER LA PUBLIC SYSTEM?

❑ Retired ❑ Refunded
❑ Active ❑ Inactive (Resigned, left contributions on deposit)

SECTION III. DESIGNATION OF PRINCIPAL BENEFICIARY(S)

I do hereby designate the following as my beneficiary: (include address if different from member)	Birthdate (Mo./Day/Yr.)	Social Security No.	Relationship
(Note: Principal beneficiary may be changed at any time prior to retirement.)			

I request the board of trustees of the Municipal Police Employees' Retirement System to pay, in the event of my death before retirement, the total amount of accumulated contributions standing to my credit in the retirement system to the designated beneficiary(s), otherwise, to my estate, unless benefits are payable to surviving spouse and/or children in accordance with Title 11 of Louisiana Revised Statutes.

Signature of Member | Date

Witness | Witness

SECTION IV. EMPLOYER CERTIFICATION (TO BE COMPLETED BY MUNICIPALITY PERSONNEL)

Employee's Position/Title | Name of Town or City | Is employee covered by Social Security? ❑ Yes ❑ No

At any time, currently or at a later date, is employee or will employee be **eligible** to receive state supplemental pay under current position/title? ❑ Yes ❑ No

If employee is not currently receiving state supplemental pay but will be **eligible** to receive state supplemental pay at a later date under current position/title, check yes.

This will certify that 100% of the services performed by the above named employee are directly under the jurisdiction and/or supervision of the Chief of Police and his/her position is part of the police department and is included in the budget of said police department. Further, 100% of the salary earned by this employee is derived from the police department budget, except for state supplemental pay, and he/she is paid at least $375.00 per month by the municipality. This employee holds a full-time position.

Signature of Appointing Authority | Title of Appointing Authority | Date

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM
MEMBER ENROLLMENT FORM

TO: Board of Trustees
Municipal Police Employees' Retirement System
7722 Office Park Boulevard, Suite 200
Baton Rouge, LA 70809-7601

I hereby certify that as a new enrollee applying for membership in the Municipal Police Employees' Retirement System (MPERS), I have six (6) months from the date of employment to complete the enrollment process and become a fully active member of MPERS. The enrollment process begins with filling out the Member Enrollment Form and Medical History, having a physical examination and sending the forms to MPERS office.

I further understand that if I complete the process within the six (6) months period following employment, I will begin vesting for regular and disability benefits from the date of my employment. **If I do not complete the process within the six (6) months period, I will not begin vesting for disability benefits until the date I complete the enrollment process, although vesting for regular retirement will begin with the date of my employment.** If I am injured in the line of duty and apply for disability benefits, I will have the responsibility of proving that the condition was not preexisting.

I understand that the provisions of Louisiana Revised Statute 11:216 state that "Any disability claimed by a member of a state or statewide retirement system must have been incurred after commencement of service in the system with which the claim is filed. Disability claims shall not be honored in the case of preexisting conditions." **This in no way affects my membership in MPERS nor my eligibility to apply for disability benefits for condition(s) not preexisting.**

I certify that all information which I provided is accurate and complete. I understand that any misrepresentation or failure on my part, intentional or unintentional, to fully disclose any information may be grounds for disqualification from and denial of disability benefits from the Municipal Police Employees' Retirement System.

I agree to all examinations and tests deemed necessary and authorize any medical information obtained to be furnished to the Municipal Police Employees' Retirement System.

Typed or Printed Name ____

Signature ____________________________ Date ________________________

Sworn to and subscribed before me this ______day of ___________________, 20____

____
Notary Public

MEDICAL HISTORY (To Be Completed By Enrollee)

FAMILY HISTORY- Mark an X in the boxes to indicate illnesses of family members and death where appropriate. Use space provided to explain items checked.

	Cause of death				Age at death	Deceased	Other Illnesses	Tuberculosis	Stroke	Stomach trouble	Sickle Cell Anemia	Rheumatism/Arthritis	Nervous trouble	Muscular Dystrophy	Migraine headaches	Liver trouble	Kidney/bladder trouble	Heart trouble	Hearing trouble	Eye disease	Epilepsy	Diabetes	Cancer/tumor	Blood pressure problems	Anemia/bleed easily	Allergies/asthma
	Other Causes	Cancer	Heart trouble	Lung disease																						
Father																										
Mother																										
Blood relatives																										

YOUR HEALTH HISTORY - Mark an X in the space next to any of the following you now have or have ever had.
USE THE SPACE PROVIDED BELOW TO EXPLAIN ALL ITEMS CHECKED IN HEALTH AND MENTAL HISTORY. GIVE COMPLETE DETAILS INCLUDING ANY ILLNESSES, SURGERIES, ACCIDENTS, OR INJURIES.

- ______ Allergies/hay fever
- ______ Amnesia
- ______ Anemia
- ______ Arthritis
- ______ Asthma
- ______ Back injury
- ______ Back pain w/out injury
- ______ Benign tumor
- ______ Bladder trouble
- ______ Bleed easily
- ______ Blood pressure problems
- ______ Bronchitis
- ______ Cancer
- ______ Carpal tunnel syndrome
- ______ Diabetes
- ______ Diphtheria
- ______ Emphysema
- ______ Epilepsy
- ______ Encephalitis
- ______ Eye disease
- ______ Eye injury
- ______ Head injury (indicate type below)
- ______ Hearing trouble
- ______ Heart trouble
- ______ Hematuria
- ______ Hepatitis
- ______ HIV (AIDS)
- ______ Infantile paralysis
- ______ Injury
- ______ Kidney trouble
- ______ Liver trouble
- ______ Lung trouble
- ______ Malaria
- ______ Migraine headaches
- ______ Multiple Sclerosis
- ______ Muscular Dystrophy
- ______ Muscular weakness
- ______ Paralysis of a body part
- ______ Osteomyelitis
- ★ ______ Positive TB test
- ______ Rheumatic Fever
- ______ Scarlet Fever
- ______ Sciatica
- ______ Seizures
- ______ Sickle Cell Anemia
- ______ Skin sores
- ______ Spinal meningitis
- ______ Stomach trouble
- ______ Stomach ulcer
- ______ Stroke
- ______ Surgery
- ★ ______ Thyroid trouble
- ______ TMJ trouble
- ★ ______ Tuberculosis
- ______ Typhold Fever
- ______ Venereal Disease (indicate type below)

★ Treatment Received?________Yes ________No

Examining physician's initials___________________

Applicant's Initials________________

MENTAL HEALTH - Have you ever been treated for: Mark an X in the space to indicate yes.

_____ Depression
_____ Insomnia
_____ Nervousness
_____ Paranoia
_____ Schizophrenia
_____ Stress

DATES	PHYSICIAN	REASON / CAUSE	TREATMENT RECEIVED	OUTCOME

FAMILY PHYSICIAN - Include name, address, phone number of physician(s) for the last 10 years.

____

____

HAVE YOU EVER BEEN: Mark an X in the space to indicate yes.
Rejected/discharged for medical reasons for:
_____ Military service?
_____ Employment?
_____ Insurance policy or rated?

EXPLAIN ANY ITEMS CHECKED ____
____
____

HAVE YOU EVER MADE A WORK-RELATED CLAIM? _____ Yes _____ No
If yes, give date and explain fully____
____

HAVE YOU HAD OR ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Mark an X in the appropriate space.

Now	Past	
		GENERAL
		1. Gained weight recently?_____________lbs.
		2. Lost weight recently?____________lbs.
______	_____	3. On a special diet
______	_____	4. Lost interest in eating.
______	_____	5. Seem to be hungry often
______	_____	6. More thirsty than usual
______	_____	7. Told too much sugar in system
______	_____	8. Tendency to be too hot or too cold
______	_____	9. Have fever or chills
______	_____	10. Feel exhausted or tired most of the time
______	_____	11. Difficulty falling or staying asleep
______	_____	SKIN
______	_____	12. Psoriasis, acne, eczema or other skin trouble
______	_____	13. Sores that won't heal
______	_____	14. X-ray treatment for skin or in neck area
______	_____	15. Skin rash due to:
______	_____	soap, detergent
______	_____	toiletries, cosmetics
______	_____	poison ivy or oak
______	_____	sunlight
______	_____	workplace
______	_____	16. Boils, skin infections
______	_____	17. Bruise easily
______	_____	18. Allergic reaction to insect bites
______	_____	19. Changes in color of skin
______	_____	20. Changes in nails or hair
______	_____	
______	_____	EYES
______	_____	21. Frequent headaches
______	_____	22. Eyesight getting worse
______	_____	23. Wear glasses
______	_____	24. Wear contact lens
______	_____	25. See double
______	_____	26. See colored halos around lights
______	_____	27. Temporary loss of sight
______	_____	28. Glaucoma
______	_____	29. Pain in eyes
______	_____	30. Difficulty in seeing
______	_____	31. Trouble in distinguishing color
______	_____	32. Blindness (indicate which eye)__________
______	_____	33. Excessive tearing
______	_____	
______	_____	EARS
______	_____	34. Others complain you don't hear them
______	_____	35. Feel you have difficulty hearing
______	_____	36. Decreased hearing after accident or loud noise
______	_____	37. Earaches or ear infections
______	_____	38. Ears draining
______	_____	39. Buzzing or ringing in ears
______	_____	40. Motion sickness in car, plane or boat
______	_____	41. Dizziness, lightheadedness or fainting
______	_____	42. Loss of balance
______	_____	43. Have hearing aid
______	_____	44. Deaf (indicate which ear)_______________
______	_____	NOSE, MOUTH, THROAT
______	_____	45. Sores or swelling of gums or jaws
______	_____	46. Trouble with tasting
______	_____	47. Nose runs when you don't have a cold
______	_____	48. Throat sore when you don't have a cold
______	_____	49. Hoarseness
______	_____	50. Frequent flowing nosebleeds
______	_____	51. Swallowing difficult or painful

Examining physician's initials ______________________ Applicant's initials ______________________

Now	Past	CHEST
______	______	52. Tightness, crushing, squeezing in chest after eating
______	______	53. Date last chest x-ray________________ Results__________________________
______	______	54. Wheeze or gasp to breathe
______	______	55. Shortness of breath
______	______	56. Coughing spells
______	______	57. Cough phlegm (thick spit)
______	______	58. Cough up blood
______	______	59. Frequent chest colds
______	______	60. Sweating more frequetly or night sweats

Now	Past	HEART
______	______	61. Told you have hypertension
______	______	62. Told you have high blood pressure
______	______	63. Thumping, racing heart or irregular heartbeat
______	______	64. Told you have heart trouble
______	______	65. Pain or tightness in chest
______	______	66. Using more pillows to help breathe when lying down

Now	Past	STOMACH/BOWEL
______	______	67. Heartburn or indigestion
______	______	68. Nervous stomach
______	______	69. Belching, bloated after eating
______	______	70. Discomfort in pit of stomach
______	______	71. Feel like vomiting
______	______	72. Vomit blood or coffee ground-like material
______	______	73. Foods that don't agree with you
______	______	74. Diarrhea or constipation (indicate which)
______	______	75. Blood in stool
______	______	76. Black, tarry or very light color stools
______	______	77. Bleeding from rectum
______	______	78. Change in bowel habits

Now	Past	URINARY SYSTEM
______	______	79. Loss of bladder control when you cough or sneeze
______	______	80. Burning or pain when you urinate
______	______	81. Brown, black or bloody urine
______	______	82. Difficulty starting urine flow or dribbling
______	______	83. Very frequent urination or feeling of need to urinate
______	______	84. Bladder infections

Now	Past	MEN ONLY
______	______	85. Urine stream weak and slow
______	______	86. Prostate trouble
______	______	87. Burning or discharge from penis
______	______	88. Sore on penis
______	______	89. Genital warts
______	______	90. Lumps or swelling on testicles
______	______	91. Undescended testicle
______	______	92. Impotence

Now	Past	WOMEN ONLY
______	______	93. Trouble with menstrual periods
______	______	94. Use of birth control pills
______	______	95. Lumps in breast or armpits
______	______	96. Bleeding, pain, discharge from nipple (indicate which)_____________________
______	______	97. Genital warts
		98. Date of last PAP smear_______________
		99. Date of last menstrual period___________
		100. Number of pregnancies______________
		101. _______Full term _______Miscarriage _______Other
		102. Date last mammogram_______________ Results____________________________

Now	Past	NERVOUS SYSTEM
______	______	103. Slurred speech or loss of speech
______	______	104. Weakness on one side of body
______	______	105. Tendency to shake or tremble
______	______	106. Dizziness or fainting
______	______	107. Numbness or tingling in any body part
______	______	108. Difficulty in walking

Now	Past	EXTREMITIES
______	______	109. Stiff, swollen or painful muscles or joints
______	______	110. Trouble stopping cuts from bleeding
______	______	111. Varicose veins
______	______	112. Vein or artery disease
______	______	113. Pains in back
______	______	114. Pains in shoulder or neck
______	______	115. Lumps, swelling in neck or glands
______	______	116. Any back problem
______	______	117. Ever worn a back brace
______	______	118. Ever worn a knee brace
______	______	119. Inflamed veins or blood clots in arms or legs
______	______	120. Numbness or tingling in cold weather
______	______	121. Cramps in legs
______	______	122. Swollen feet or ankles
______	______	123. Painful feet
______	______	124. Burning of soles of feet

Now	Past	TOBACCO
______	______	125. Use tobacco in any form
______	______	126. If yes, specify form ______Cigarettes ______Cigars ______Pipe ______Chew tobacco ______Dip snuff
______	______	127. Amount daily_______________
______	______	128. How many years____________
______	______	129. If you no longer use tobacco, month and year you stopped_______________

Now	Past	DRUGS
______	______	130. Illegal use of controlled drugs
______	______	131. Treated for durg problem If yes, when and where________________ ___________________________________

Now	Past	ALCOHOLIC BEVERAGES
______	______	132. Use alcoholic beverage of any kind
______	______	133. Frequency________________________
______	______	134. How much - 1 drink = 1 jigger alcohol, 1 beer or 1 glass wine (Mark an X in appropriate box)

Less than 1	1-2	2-4	5-6	More than 6
☐	☐	☐	☐	☐

Now	Past	
______	______	135. Been told you have a drinking problem
______	______	136. Do you have a drinking problem
______	______	137. Ever treated for alcohol problem If yes, when and where________________

Examining physician's initials______________

Applicant's initials______________

MEDICINES - Mark an X in the space to indicate medicines you have ever taken or are now taking.

Now	Past		Now	Past		Now	Past	
______	______	Antacids	______	______	Dilantin/anticonvulsants	______	______	Nose drops
______	______	Antibiotics	______	______	Diuretics/water pills	______	______	Sedatives
______	______	Birth control pills	______	______	Heart medicine	______	______	Stimulants
______	______	Blood thinners	______	______	Blood pressure medicine	______	______	Tranquilizers
______	______	Codeine	______	______	Insulin	______	______	______________
______	______	Cortisone-type drugs ★	______	______	Laxatives	______	______	______________
______	______	Diet pills	______	______	Muscle relaxants	______	______	______________

★ Specify reason for use of cortisone-type drug (infection, injury, arthritis) ______________________________

____

List dosage and frequency of medicines you are currently taking______________________________

____

____

List all medicines you are allergic to ______________________________

____

PART B – PHYSICAL EXAMINATION

Applicant's Name______________________________

PHYSICAL EXAMINATION - To be completed by physician performing examination. Indicate every item which is not within normal limits by placing an X in space provided.

1. GENERAL
   - Posture ______
   - Gait ______
2. SKIN
   - Color ______
   - Texture ______
   - Sweaty______
   - Scars ______
   - Eruptions ______
   - Ulcers ______
   - Petechiae ______
3. HEAD
   - Shape ______
   - Hair ______
   - Masses ______
   - Tenderness ______
   - Bruit______
   - Sinus ______
4. EARS
   - External______
   - Pinna ______
   - Canal ______
   - Drum ______
5. EYES
   - Muscles______
   - Lids ______
   - Conjunctivae ______
   - Cornea______
   - Pupils______
   - Fundi ______
   - Macula______
   - Disk ______
   - Arteries ______
   - Veins ______
   - Exudate ______
6. MOUTH/THROAT
   - Lips ______
   - Breath ______
   - Mucosa ______
   - Dentures ______
   - Teeth ______
   - Tongue ______
   - Gingiva ______
   - Floor ______
   - Palate ______
   - Pharynx ______
   - Tonsilis ______
   - Larynx ______
7. NOSE
   - Septum ______
   - Obstruction ______
   - Mucosa ______
   - Sinus ______
8. NECK
   - Thyroid ______
   - Trachea ______
   - Veins ______
   - Masses ______
   - Bruit______
   - Carotid______
   - Spine ______
   - Range of Motion ______
9. LUNGS
   - Expansion ______
   - Breath sounds ______
   - Rales ______
   - Wheezes ______
   - Rubs ______
   - Rhonchi ______
   - Respiratory rate______
10. HEART
    - Rate______
    - Rhythm ______
    - Thrill______
    - Masses ______
    - Rubs ______
    - Murmurs ______
    - Gallops ______
11. BREASTS
    - Nodes ______
    - Discharge ______
    - Nipple ______
    - Areola ______
    - Symmetry ______
    - Consistency______
    - Scars ______
    - Masses ______
12. ABDOMEN
    - Contour ______
    - Tenderness ______
    - Masses ______
    - Hernia ______
    - Liver size______cm
    - Liver edge ______
      - Smooth ______
      - Irregular______
      - Nodular ______
    - Spleen size ______
    - CVA tenderness ______
    - Rebound ______
13. FEMALE GENITO-URINARY
    - Labia ______
    - Clitoris ______
    - Bartholin's gland ______
    - Urethra ______
    - Perineum______
    - Introitus ______
    - Vagina ______
    - Cervix ______
    - Uterus ______
    - Adnexa ______
    - Cul-de-sac______
    - Discharge ______
14. MALE GENITO-URINARY
    - Penis ______
    - Meatus______
    - Epididymis______
    - Varicocele ______
    - Testicles ______
    - Discharge ______
    - Hernia ______
    - Prostate______
    - Scars ______
15. RECTAL
    - Anus ______
    - Sphincter______
    - Hemorrhoids ______
    - Mucosa
    - Masses ______
    - Pilonidal______
    - Fissure______
16. NEUROLOGIC
    - Grasp______
    - Plantar______
    - Biceps ______
    - Triceps______
    - Knee ______
    - Ankle ______
    - Romberg ______
    - Babinski______
    - Coordination ______
    - Tremor______
    - Vibratory ______
    - Cranial Nerves______
    - Sensory ______
17. MUSCULOSKELETAL
    - Shoulder ______
    - Arm ______
    - Elbow______
    - Radial pulse______
    - Wrist ______
    - Hand ______
    - Fingers ______
    - Fingernails______
    - Spine ______
      - Kyphosis ______
      - Lordosis______
      - Scoliosis ______
    - Hip______
    - Leg______
    - Knee ______
    - Ankle ______
    - Foot ______
    - Pedal pulse ______
    - Toes ______
    - Toenails______
    - Joints______
18. EXTREMETIES
    - Clubbing ______
    - Cyanosis ______
    - Edema ______
    - Veins ______
    - Stasis______
    - Ulceration ______
    - Hair distribution ______
19. EMOTIONAL
    - Speech ______
    - Affect ______
    - Orientation______
    - Memory ______

Examining physician's initials______ Applicant's initials______

Height ________________ Weight ________________ Temperature ________________

Blood Pressure ________________ If 140/90 or above, recheck in 5 minutes________________

Pulse before exercise ________________ After jogging in place 1 minute ________________ After 2 minutes rest ________________

Vision uncorrected________________ Corrected________________

Hearing (20 feet) ________________ Rinne ________________ Weber ________________

LABORATORY INFORMATION - Attach Reports

SMA 24 (fasting)

Routine urinalysis

CBC

Urine drug screen - To include amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, opiates, phencyclidine

Indicate Results

VDRL________________ TB skin test ________________

AIDS (HIV)________________

Remarks on laboratory results________________

____

____

List every item which needs explanation, including items from family history, applicant's history, physical examination and laboratory results.

PROBLEM	PLAN

From your examination of ________________, do you consider applicant to have any pre-existing conditions that would disqualify the applicant from a disability retirement with the retirement system?________________

If yes, please list pre-existing conditions ________________

____

____

This examination and resulting information truly depicts the condition of the applicant on the ________________day of ________________ , ______ .

____
Examining physician's name (Type or Print)

____
Examining physician's signature

____
Address

____
Telephone No.