

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM

Rev. 10/2024

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

MEMBER ENROLLMENT FORM

Municipality No.

To Be Completed By MPERS

SECTION I. EMPLOYEE INFORMATION

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

SOCIAL SECURITY #:

Name (Last, First, Middle Initial)					MARITAL STATUS (Check One)				
Mailing Address					<input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Single /Never married <input type="checkbox"/> Divorced				
City	State	Zip Code	Area Code ()	Telephone No.	Date of Birth	Mo	Day	Year	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Personal Email									

Original Date of Employment at Police Dept.	Mo	Day	Year	MPERS Entry Date	Mo	Day	Year
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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: <input type="checkbox"/> Refunded <input type="checkbox"/> Transfer <input type="checkbox"/> Inactive
B. Are you now or have you ever been a member of another Louisiana Public Retirement System? If Yes, which one(s) (list):	<input type="checkbox"/> Yes <input type="checkbox"/> No	From (Mo./Yr.)	To (Mo./Yr.)

WHAT IS YOUR PRESENT STATUS IN OTHER LA PUBLIC SYSTEM?	<input type="checkbox"/> Retired <input type="checkbox"/> Refunded <input type="checkbox"/> Active <input type="checkbox"/> Inactive (Resigned, left contributions on deposit)
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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
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Witness	Witness
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SECTION IV. EMPLOYER CERTIFICATION (TO BE COMPLETED BY MUNICIPALITY PERSONNEL)

Employee's Position/Title (Include copy of job description)	Name of Town or City	Is employee covered by Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No Is position/title a Civil Service position? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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
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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 ninety (90) days 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, including a copy of my birth certificate and social security card.**

I further understand that if I complete the process within the ninety (90) day 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 ninety(90) day 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																							
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.

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

____ Insurance policy or rated?

____ Employment?

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

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 frequently or night sweats
		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
		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
		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
		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
		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) _____

Now	Past	
_____	_____	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 _____
		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
		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
		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 _____
		DRUGS
_____	_____	130. Illegal use of controlled drugs
_____	_____	131. Treated for drug problem If yes, when and where _____
		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
_____	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	_____	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.

- | | | | |
|--|--|---|---|
| <p>1. GENERAL</p> <p>Posture _____</p> <p>Gait _____</p> | <p>7. NOSE</p> <p>Septum _____</p> <p>Obstruction _____</p> <p>Mucosa _____</p> <p>Sinus _____</p> | <p>Tenderness _____</p> <p>Masses _____</p> <p>Hernia _____</p> <p>Liver size _____ cm</p> <p>Liver edge _____</p> <p>Smooth _____</p> <p>Irregular _____</p> <p>Nodular _____</p> <p>Spleen size _____</p> <p>CVA tenderness _____</p> <p>Rebound _____</p> | <p>Biceps _____</p> <p>Triceps _____</p> <p>Knee _____</p> <p>Ankle _____</p> <p>Romberg _____</p> <p>Babinski _____</p> <p>Coordination _____</p> <p>Tremor _____</p> <p>Vibratory _____</p> <p>Cranial Nerves _____</p> <p>Sensory _____</p> |
| <p>2. SKIN</p> <p>Color _____</p> <p>Texture _____</p> <p>Sweaty _____</p> <p>Scars _____</p> <p>Eruptions _____</p> <p>Ulcers _____</p> <p>Petechiae _____</p> | <p>8. NECK</p> <p>Thyroid _____</p> <p>Trachea _____</p> <p>Veins _____</p> <p>Masses _____</p> <p>Bruit _____</p> <p>Carotid _____</p> <p>Spine _____</p> <p>Range of Motion _____</p> | <p>13. FEMALE GENITO-URINARY</p> <p>Labia _____</p> <p>Clitoris _____</p> <p>Bartholin's gland _____</p> <p>Urethra _____</p> <p>Perineum _____</p> <p>Introitus _____</p> <p>Vagina _____</p> <p>Cervix _____</p> <p>Uterus _____</p> <p>Adnexa _____</p> <p>Cul-de-sac _____</p> <p>Discharge _____</p> | <p>17. MUSCULOSKELETAL</p> <p>Shoulder _____</p> <p>Arm _____</p> <p>Elbow _____</p> <p>Radial pulse _____</p> <p>Wrist _____</p> <p>Hand _____</p> <p>Fingers _____</p> <p>Fingernails _____</p> <p>Spine _____</p> <p> Kyphosis _____</p> <p> Lordosis _____</p> <p> Scoliosis _____</p> <p>Hip _____</p> <p>Leg _____</p> <p>Knee _____</p> <p>Ankle _____</p> <p>Foot _____</p> <p>Pedal pulse _____</p> <p>Toes _____</p> <p>Toenails _____</p> <p>Joints _____</p> |
| <p>3. HEAD</p> <p>Shape _____</p> <p>Hair _____</p> <p>Masses _____</p> <p>Tenderness _____</p> <p>Bruit _____</p> <p>Sinus _____</p> | <p>9. LUNGS</p> <p>Expansion _____</p> <p>Breath sounds _____</p> <p>Rales _____</p> <p>Wheezes _____</p> <p>Rubs _____</p> <p>Rhonchi _____</p> <p>Respiratory rate _____</p> | <p>14. MALE GENITO-URINARY</p> <p>Penis _____</p> <p>Meatus _____</p> <p>Epididymis _____</p> <p>Varicocele _____</p> <p>Testicles _____</p> <p>Discharge _____</p> <p>Hernia _____</p> <p>Prostate _____</p> <p>Scars _____</p> | <p>18. EXTREMITIES</p> <p>Clubbing _____</p> <p>Cyanosis _____</p> <p>Edema _____</p> <p>Veins _____</p> <p>Stasis _____</p> <p>Ulceration _____</p> <p>Hair distribution _____</p> |
| <p>4. EARS</p> <p>External _____</p> <p>Pinna _____</p> <p>Canal _____</p> <p>Drum _____</p> | <p>10. HEART</p> <p>Rate _____</p> <p>Rhythm _____</p> <p>Thrill _____</p> <p>Masses _____</p> <p>Rubs _____</p> <p>Murmurs _____</p> <p>Gallops _____</p> | <p>15. RECTAL</p> <p>Anus _____</p> <p>Sphincter _____</p> <p>Hemorrhoids _____</p> <p>Mucosa _____</p> <p>Masses _____</p> <p>Pilonidal _____</p> <p>Fissure _____</p> | <p>19. EMOTIONAL</p> <p>Speech _____</p> <p>Affect _____</p> <p>Orientation _____</p> <p>Memory _____</p> |
| <p>5. EYES</p> <p>Muscles _____</p> <p>Lids _____</p> <p>Conjunctivae _____</p> <p>Cornea _____</p> <p>Pupils _____</p> <p>Fundi _____</p> <p>Macula _____</p> <p>Disk _____</p> <p>Arteries _____</p> <p>Veins _____</p> <p>Exudate _____</p> | <p>11. BREASTS</p> <p>Nodes _____</p> <p>Discharge _____</p> <p>Nipple _____</p> <p>Areola _____</p> <p>Symmetry _____</p> <p>Consistency _____</p> <p>Scars _____</p> <p>Masses _____</p> | <p>16. NEUROLOGIC</p> <p>Grasp _____</p> <p>Plantar _____</p> | |
| <p>6. MOUTH/THROAT</p> <p>Lips _____</p> <p>Breath _____</p> <p>Mucosa _____</p> <p>Dentures _____</p> <p>Teeth _____</p> <p>Tongue _____</p> <p>Gingiva _____</p> <p>Floor _____</p> <p>Palate _____</p> | <p>12. ABDOMEN</p> <p>Contour _____</p> | | |

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

Metabolic Panel

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. _____