

## APPLICATION FOR DISABILITY

**Department of State Treasurer, Firemen's and Rescue Squad Workers' Pension Fund**  
325 North Salisbury Street, Raleigh, North Carolina 27603-1385

Name \_\_\_\_\_ S.S. No. \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_  
Fire  Rescue  Department Name \_\_\_\_\_

---

### DISABILITY INFORMATION:

1. Date of disability \_\_\_\_\_
2. Indicate principal cause of disability \_\_\_\_\_
3. Was disability the result of a line of duty injury? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, describe how the injury occurred. \_\_\_\_\_  
\_\_\_\_\_

Are you a member of the Local Governmental Employees' Retirement System or Teachers' and State Employees' Retirement System? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, have you applied or been approved for disability benefits under either the Local System or State System? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, it will not be necessary for the Medical Report Form 7B to be completed. Otherwise, Form 7B must be completed by your physician before your application can be given consideration by the Medical Board.

### MEMBER CERTIFICATION:

I hereby certify that the above information is true and correct to the best of my knowledge under penalty of law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

---

### DEPARTMENT CERTIFICATION:

I hereby certify that the information on the above-named person is true and correct to the best of my knowledge under penalty of law.

Authorized  
Signature \_\_\_\_\_ Title \_\_\_\_\_  
Telephone No. ( ) \_\_\_\_\_ Date \_\_\_\_\_