CITY OF NORTH PORT
POLICE OFFICERS' PENSION - LOCAL OPTION TRUST FUND

AFFIDAVIT OF DISABILITY BENEFIT RECIPIENT
(Not to be used with Application for Disability Retirement)

Before me, the undersigned authority, personally appeared ________________________, who being duly sworn deposes and says:

1. I am currently receiving disability retirement benefits from the City of North Port Police Officers' Pension - Local Option Trust Fund.

2. In the immediately preceding calendar year, I received income from the following sources:

   a. Workers' Compensation. Yes [ ] No [ ]

   b. Any employer. Yes [ ] No [ ]

   c. Self-employment. Yes [ ] No [ ]

   d. Other earned income. Yes [ ] No [ ]
   If yes, please state the source.

3. My current employment involves the following physical activities:

4. The current status of the condition upon which my disability benefits are based and my limitations resulting from such condition are as follows:

5. I engage in the following sports and recreational activities:

6. Attached is my treating physician's report specifically and completely stating:

   a. The status of the condition upon which my disability benefits are based.

   b. That I remain totally and permanently disabled from rendering useful and efficient service as a police officer and the reasons therefor.

   c. The restrictions and limitations resulting from such condition.

7. Attached is additional information that I deem relevant for the Board's consideration in reviewing my continued benefit entitlement. ____ yes ____ no

8. I authorize the Board to utilize this affidavit and any attachments in any public meetings it may have regarding my disability status. I further waive any statutory or common law right of privacy I may have in these records, if necessary to enable the Board to discuss these records in any public meetings in connection with my disability status.

____
Signature

STATE OF __________________
COUNTY OF ________________

Sworn to (or affirmed) and subscribed before me, by means of ☐ physical presence or ☐ online notarization, this __ day of ________, 20_____ by ___________________________.

____
Notary Public

____
Name typed, printed or stamped

My Commission Expires: ____________

Personally known ___________ OR Produced Identification ____________
Type of Identification Produced:____.

* **This form is to be completed only by those persons <u>currently</u> receiving disability benefits.**