CORRECTIONS OFFICERS RETIREMENT PLAN

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FORM C5-LB-A
10/2024

ACCIDENTAL DISABILITY QUESTIONNAIRE

Completed by Local Board and Medical Board (as applicable)

PRINT INFORMATION:

NAME OF EMPLOYER _____ NAME OF EMPLOYEE _____

Pursuant to A.R.S. §§ 38-881(1) and 38-886, an "Accidental Disability" means a physical or mental condition that the local board finds totally and permanently prevents an employee from performing a reasonable range of duties within the employee's department and was incurred in the performance of the employee's duties.		**Local Board Response**	
1)	Did the employee file the application after the disabling incident, or within one year of ceasing to be an employee?	☐ YES	☐ NO
2)	Did (or will) the employee terminate by a reason of disability?	☐ YES	☐ NO
3)	Did employment terminate based on a disciplinary issue?	☐ YES	☐ NO
4)	Is the employee still working in a CORP designated position that the local board considers a reasonable range of duties within the employee's department?	☐ YES	☐ NO
5)	Has the employee refused a CORP designated position that the local board considered a reasonable range of duties within the employee's department?	☐ YES	☐ NO
6)	Did the injury or condition occur prior to the current CORP membership date?	☐ YES	☐ NO
7)	Was the injury or condition the result of an event incurred during the performance of the employee's duty?	☐ YES	☐ NO

LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB, provide copy of supporting documents and local board meeting minutes to the CORP. If the employee may qualify, an independent medical examination (*IME*) will need to be performed. Sign/date this questionnaire and forward, including copy of all medical evidence, job classification/description, current CORP membership date and any additional questions to the Medical Board.

MEDICAL BOARD (PHYSICIAN) INSTRUCTIONS: In addition to an independent medical examination (*IME* report), answer the following questions, sign/date and return to the local board. Provide additional comments in the IME report.		**Physician Response**	
1)	Does the employee have the physical or mental condition that is the basis for the disability application?	☐ YES	☐ NO
2)	Does the injury or condition **totally** and **permanently** prevent the employee from performing a reasonable range of duties in a CORP designated position within the employee's department? To the extent possible, explain in the IME report those duties the employee's injury or condition would totally and permanently prevent the employee from performing.	☐ YES	☐ NO
3)	Was the injury or condition the result of an event incurred during the performance of the employee's duty?	☐ YES	☐ NO
4)	During your examination of all medical evidence, did you discover any pre-existing conditions or injuries that contributed to the claimed disability? If yes, please explain in the IME report. ("Pre-existing" is defined as occurring prior to the employee's current CORP membership date.)	☐ YES	☐ NO
5)	Are there conflicts in the medical evidence? If yes, please explain in the IME report.	☐ YES	☐ NO

LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the local board meeting minutes.
LOCAL BOARD AND PHYSICIAN: By the signature below, I/we attest that the medical records have been thoroughly reviewed, each section has been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my/our knowledge and belief.

PRINT NAME OF LOCAL BOARD SECRETARY OR CHAIRMAN _____ SIGNATURE _____ DATE _____

PRINT PHYSICIAN'S NAME AND TITLE (E.G., M.D) _____ SIGNATURE _____ DATE _____