

PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

FORM P5-LB-C

3010 East Camelback Road, Suite 200
 Phoenix, Arizona 85016-4416
 (602) 255-5575 | www.psprs.com

10/2024

CATASTROPHIC DISABILITY QUESTIONNAIRE
Completed by Local Board and Medical Board (as applicable)

PRINT INFORMATION:

NAME OF EMPLOYER

NAME OF EMPLOYEE

| Pursuant to A.R.S. §§ 38-842(9), 38-844, 38-845 and Section 11, a "Catastrophic Disability" means a physical and not a psychological condition that the local board determines prevents the employee from totally and permanently engaging in any gainful employment and that results from a physical injury incurred in the performance of the employee's duty. | Local Board Response |
|---|--|
| 1) Did the employee file the application after the disabling incident, or within one year of ceasing to be an employee? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2) Did (or will) the employee terminate by a reason of disability? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3) Did employment terminate based on a disciplinary issue? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4) If the member's period of DROP has ended, if applicable, did (or will) the employee terminate by a reason of disability? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5) Is the employee still working in a position the local board considers gainful employment? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6) Did the injury occur prior to the current PSPRS membership date? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7) Was the injury the result of an event incurred during the performance of the employee's duty? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does <u>not</u> qualify, complete FORM P5-LB, provide copy of supporting documents and local board meeting minutes to the PSPRS. 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 PSPRS 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 condition that is the basis for the disability application? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2) Does the physical injury totally prevent the employee from engaging in any gainful employment? To the extent possible, explain in the IME those duties the employee's injury would totally prevent the employee from engaging in any gainful employment. | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3) Does the physical injury permanently prevent the employee from engaging in any gainful employment? To the extent possible, explain in the IME those duties the employee's injury would permanently prevent the employee from engaging in any gainful employment. | <input type="checkbox"/> YES <input type="checkbox"/> 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 PSPRS membership date.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5) Was the injury the result of an event incurred during the performance of the employee's duty? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6) Are there conflicts in the medical evidence? If yes, please explain in the IME report. | <input type="checkbox"/> YES <input type="checkbox"/> 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