

# Applicant's Statement of Disability

## In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees' Retirement System

Civil Service  
Retirement System

Federal Employees'  
Retirement System

*A copy of this completed form must accompany the Supervisor's Statement that you give  
your supervisor(s).*

1. Name (last, first, middle)	2. Date of birth (mo./day/yr.)	3. Social security number
4. Fully describe your disease(s) or injury(ies.) We consider only the diseases and/or injuries you discuss in this application.		
5. Describe how your disease(s) or injury(ies) interferes with performance of your duties, your attendance, or your conduct.		
6. Describe any other restrictions of your activities imposed by your disease or injury.		
7a. What accommodations have you requested from your agency?		
7b. Has your agency been able to grant your request? (Attach an explanation or any documentation that you have regarding accommodation.) <input type="checkbox"/> Yes <span style="margin-left: 200px;"><input type="checkbox"/> No</span>		
7c. What is your current status with your agency? <input type="checkbox"/> In pay status; and working without accommodation. <span style="margin-left: 100px;"><input type="checkbox"/> In leave without pay status. *</span> <input type="checkbox"/> In pay status; and working with accommodation <span style="margin-left: 100px;"><input type="checkbox"/> Separated from service*</span> <i>*If you are currently in a leave without pay status or separated from service, what job(s), if any, have you performed since going into this status. Please explain the physical and/or mental requirements for this (those) job(s).</i>		
8. Give the approximate date you became disabled for your position (mo./yr.).	9. Have you been hospitalized for your disease or injury as described in item 4? <input type="checkbox"/> Yes <span style="margin-left: 20px;"><input type="checkbox"/> No</span>	10. Give date of most recent hospitalization. From (mo./yr.) <span style="margin-left: 20px;">To (mo./yr.)</span>
11. <i>Notice for FERS and CSRS Offset Applicants ONLY</i>  <i>Application for disability retirement under FERS or CSRS Offset requires an application for Social Security Disability Benefits. Final Processing at OPM cannot be completed without a copy of your Social Security application receipt or award notice.</i>		
11a. Have you applied for disability benefits from the Social Security Administration?  <input type="checkbox"/> Yes <span style="margin-left: 100px;"><input type="checkbox"/> No</span>	11b. Is the application receipt or award notice attached?  <input type="checkbox"/> Yes <span style="margin-left: 100px;"><input type="checkbox"/> No</span>	

12. List physician(s), (name(s), address(es), and dates of treatment) from whom you plan to request Physician's Statements (SF 3112C)). Attach an additional sheet if you wish to list more physicians.

Name	Address	Date of Treatments
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<b>Applicant's Consent and Certification</b>	I certify that all statements made above are true to the best of my knowledge and belief. I give my permission for the release of information about my service and medical condition(s)(i.e., disease or injury) to authorized agency and OPM officials. I have read and understand all of the information provided in the instructions to this application.
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<b>WARNING:</b> Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)	Signature ( <i>Do not print</i> )	
	Date ( <i>mo./day/yr.</i> )	Daytime telephone number ( <i>incl. area code</i> )

**Privacy Act Statement**

Solicitation of this information is authorized by the Civil Service Retirement law (Chapter 83, title 5, U.S. Code) and by the Federal Employees' Retirement law (Chapter 84, title 5, U.S. Code). The information you furnish will be used to identify records properly associated with your application for Federal Benefits, to obtain additional information if necessary, to determine and allow present or future benefits, and to maintain a uniquely identifiable claim file. The information may be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies in order to determine benefits under their programs, to obtain information necessary for determination or continuation of benefits under this program, or to report income for tax purposes. It may also be shared and verified, as noted above, with law enforcement agencies when they are investigating a violation or potential violation of the civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number. Furnishing the Social Security Number, as well as other data, is voluntary, but failure to do so may delay or make it impossible for us to determine your eligibility to receive benefits.

**Public Burden Statement**

We think this form takes an average 30 minutes per response to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Reports and Forms Manager, Paperwork Reduction Project (3206-0228), Washington, D.C. 20415. The OMB number, 3206-0228, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.