



APPLICATION FOR DISABILITY RETIREMENT EMPLOYER'S STATEMENT AND REPORT

PO Box 48380 Olympia, WA 98504-8380 • www.drs.wa.gov
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Part 2 of 3

Retirement System (check one):	<input type="checkbox"/> LEOFF	<input checked="" type="checkbox"/> PERS	<input type="checkbox"/> PSERS	<input type="checkbox"/> SERS	<input type="checkbox"/> TRS
Plan (check one):	<input type="checkbox"/> Plan 1	<input checked="" type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3		

Member Information (to be completed by member)

Name (Last, First, Middle) Doe, Jane A.		Social Security Number XXX-XX-XXXX
Employer Thurston County	Division/Section Auditor	Date Separated from Employment 01/31/2012
Immediate Supervisor's Name Boss, Imogene M.		Supervisor's Phone Number (XXX) XXX-XXXX

Employee's Current Status (to be completed by employer)

Please provide employee's current status. Employee is:

Currently working

full duties full work schedule
 modified work duties modified work schedule

Currently in leave status

Date leave commenced (mm/dd/yyyy) _____

Last date of paid leave (mm/dd/yyyy) _____

Has member received shared leave?

Yes No

Terminated

Position Information (to be completed by employer)

Briefly describe the employee's most recent position and list all positions the employee has held with your department.
Attach job descriptions for each position.

Administrative Assistant 3 -- Administrative Assistant 3 responsible for maintaining and managing multiple database programs; mailing notice letters; coordinating and setting up office meetings and appointments; answering phone calls from customers.
Office Assistant 2
Records Clerk

In your opinion, can the employee perform the duties of their most recent position?
 Yes No

In your opinion, can the employee perform the duties of any other position?
 Yes No See comment section below.

If yes, what other positions?

Are any of these positions currently available?
 Yes No Non-applicable

Comments:
Employee's physical condition severely limits her manual dexterity and mental abilities to manage high volume computer work, multi-task, and communicate clearly with customers. Employee has extreme weakness and fatigue.

Complete and sign the back of this form before returning



Disability Information (to be completed by employer)

State the nature of the disability to the best of your knowledge.

Per letter from employee's physician presented to HR by Ms. Doe, employee has multiple sclerosis which is progressing at this time. Employee experiences extreme weakness and fatigue, has an unstable gait and difficulty walking, some double vision and short-term memory loss.

When did the accident occur, or occupational disease or other disability become evident? (mm/dd/yyyy) 02/16/2011

Did the disability occur as a result of an accident or occupational disease occurring in the performance of duty and without negligence on the part of the employee while employed with your department?

Yes No

If yes, describe the accident and the resulting condition:

Are you a Self-Insured Employer?

Yes No

If yes, provide contact name and phone number:

Have you attempted reasonable accommodation for this member according to the Americans with Disabilities Act?

Yes No

Please provide details:

Performed an updated ergonomic assessment; provided a flexible work schedule to help employee cope with extreme fatigue and to allow her more flexibility in coordinating her medical appointments; non-essential duties were removed from job responsibilities; provided ergonomic keyboard and voice recognition software to reduce keyboarding duties.

Certification of Statement (to be completed by employer)

I certify that the information on this form is true and complete to the best of my knowledge and belief.

Name (please print) Imogene M. Boss		Phone Number (xxx) XXX-XXXX	
Mailing Address 1234 Main Street	City Your City	State WA	ZIP XXXXX-XXXX
E-mail Address Im.Boss@thurstonco.wa.gov		Fax Number (xxx) XXX-XXXX	
Signature <i>Imogene M Boss</i>	Title Human Resources Manager	Date 02/15/2012	

Important Note: A determination of disability retirement can be made prior to the member's separation, but no benefits can be paid until the member is separated from employment on the transmittal report.

ATTACH A COPY OF THE JOB DESCRIPTIONS