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| **RECERTIFICATION OF DISABILITY RETIREMENT** |
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|  |  |  |  |  |  | Date |       |
| TO THE BOARD OF TRUSTEES: |
| In accordance with the provisions of Act 454 of 1949, I, the undersigned, hereby make application to recertify for disability which disqualifies me for active service. I further specifically acknowledge that the use of any and all documents submitted as part of this application and any and all documents or other items considered by the Arkansas State Highway Employees’ Retirement System (‘ASHERS’) is limited to the consideration of this application only. I further specifically and irrevocably waive the use of any decision of ASHERS in any proceeding before or related to the Arkansas Workers’ Compensation Commission. |
|  |  |  |  |  |  |
|  |  |  |  |  | Signature of Applicant |
|  |  |  |  |  |  |  |  |  |  |
| 1. | Applicant’s full name |       |
|  |  |  |  |  |  |  |  |  |  |
| 2. | Date of Birth |       | 3. | Social Security Number |       |
|  |  |  |  |  |  |  |  |  |  |
| 4. | Present Address |       |
|  |  |  |  |  |  |  |  |  |  |
| 5. | Where last employed |       | 6. | When ceased to be employed? |       |
|  |  |  |  |  |  |  |  |  |  |
| 7. | Were you compelled to stop work by reason of your present illness? |       |
|  |  |  |  |  |  |  |  |  |  |
| 8. | How much have you earned at gainful work since you ceased to be employed by the Arkansas Department of Transportation? |
|  | Current Year 2021 $ |       |  | Explain |       |
|  | Previous Year 2020 $  |       |  | Explain |       |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| 9. | When did you last consult a physician for your present illness? |       |
|  |  |  |  |  |  |  |  |  |  |
| 10. | Has your condition shown improvement? |       |
|  |  |  |  |  |  |  |  |  |  |
| 11. | Are you able to engage in any gainful employment? |       |
|  |  |  |  |  |  |  |  |  |  |
| 12. | Nature of complaint? |       |
|  |  |  |  |  |  |  |  |  |  |
| 13. | Give name and address of present attending physician and other physicians consulted: |
|  |  |  |  |  |  |  |  |  |  |
|  | Name |       |  | Name |       |
|  |  |  |  |  |  |  |  |  |  |
|  | Address |       |  | Address |       |
|  |  |  |  |  |  |  |  |  |  |
|  |       |  |       |
|  |  |  |  |  |  |  |  |  |  |
| 14. | List institutions, if any, at which treatment has been received for conditions causing present disability: |
|  |  |  |  |  |  |  |  |  |  |
|  | Name of Institution |       |  | Address |       |
|  |  |  |  |  |  |  |  |  |  |
|  |       |  |       |
|  |  |  |  |  |  |  |  |  |  |
|  |       |  |       |
|  |  |  |  |  |  |  |  |  |  |
| **FORM MUST BE NOTARIZED** |
| State of  |  | County of  |  |  |
| Subscribed and sworn to before me on this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_.  |
|  |  |  |  |  |  |  |  |
|  |  | Notary Public |  |
|  (SEAL) |
|  |  My commission expires |  |
|  |  |  |  |  |  |  |  |

 (A fully executed original and duplicate of this form must be filed with the Executive Secretary upon request.)

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|  |  |  |  |  |
| HIPAA AUTHORIZATION FORM |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | I hereby authorize use or disclosure of protected health information about me as described below. |  |
|  |  |  |  |  |  |  |
|  | 1. The following specific person or facility is authorized to make disclosure. |  |
|  |  Submit a form for each provider care. |  |
|  |  |  |  |
|  |       |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | 2. The following person or facility may receive disclosure of protected health information |  |
|  | about me: |  |  |  |
|  |  | Robyn M. Smith |  |  |
|  |  | Arkansas State Highway Employees’ Retirement |  |  |
|  |  | P.O. Box 2261 Little Rock, AR 72203 |  |
|  |  |  |  |
|  |  |  |  |  |  |  |
|  | 3. The specific information that should be disclosed is: |  |  |  |
|  |  |  |  |  |  |  |
|  | Any and all information you may give regarding the medical condition for which I have consulted you, including history, findings, diagnosis, treatment given, condition now or at discharge and prognosis. |  |
|  |  |  |  |  |  |  |
|  | 4. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations. |  |
|  |  |  |  |  |  |  |
|  | 5. I may revoke this authorization by notifying | Robyn M. Smith | in writing. However, I understand that any action |  |
|  | already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. |  |
|  |  |  |  |  |  |  |
|  | 6. This authorization expires on |       | , 20 |    | , | OR upon occurrence of the following event that |  |
|  | relates to me or to the purposed of the intended use or disclosure of information about me: |  |
|  |       | . |  |  |
|  |  |  |  |  |  |  |
|  | 7. This form is for the purpose of receiving information to ascertain if the employee qualifies for Disability Retirement. |  |
|  |  |  |  |  |  |  |
|  | **THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.** |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | Signature of Individual |  | Date of Signature |  | Date of Birth or Social Security Number |  |
|  | (The person about whom the information relates) |  |  |  |  |
|  |  |  |  |  |  |  |
|  | --OR, if applicable-- |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | Signature of Guardian or |  | Date of Signature |  | Date of Guardianship |  |
|  | Personal Representative |  |  |  |  |  |