PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
10 CABOT ROAD, SUITE 300 | MEDFORD, MA 02155

Introduction
Employer's Statement Pertaining to an Application for Disability Retirement

Form Last Revised: May, 2025

Who should prepare this form?

In accordance with 840 CMR 10.07 (Code of Massachusetts Regulations), the *Employer's Statement* should be prepared by the head of the department that employs the disability retiree applicant. However, if the department head does not supervise the applicant, the applicant's direct supervisor should prepare and sign this statement and it should be counter-signed by the department head.

What is the timeframe associated with this form?

The signed *Employer's Statement* should be completed and filed with the applicant's retirement board **within fifteen days of its being received by the employer**. Forms missing required signatures will be returned.

Who will ask the employer to complete this form?

In the retirement application that an applicant submits to his/her retirement board, the applicant will identify the name and address of his/her department head and his/her direct supervisor.

The retirement board will send a copy of the *Employer's Statement* to the applicant's department head and request that the form be completed, regardless of whether this is a voluntary or involuntary application.

If an employer has questions about this form, who should be contacted?

If an employer needs further explanation about this form or the disability process in general, the employer should contact the member's retirement board *(see next page for contact information)*.

What documents must the employer attach to the *Employer's Statement*?

- A copy of the applicant's current official job description. In that job description, the employer must designate those duties that are essential. Employers should use the "Determination of Essential Duties" section of the *Employer's Statement* as a guideline.
- Copies of any and all records regarding the applicant's physical condition at the time of his or her employment with the department (for example, a pre-employment physical examination).
- Copies of any and all records regarding the applicant's physical condition after he or she was employed by the department.
- Copies of all reports or investigations concerning the applicant's incidents or hazards.
- Copies of any and all Workers' Compensation incident reports and/or any Workers' Compensation settlement agreements made on behalf of the applicant.
- Copies of any and all reports associated with the applicant's Massachusetts General Laws, Chapter 41, Section 111F benefits.

Please return to the Applicant's Retirement Board within 15 days of receipt:

Name of Retirement Board:			
Address:			
City/Town:		**Zip Code:**	
Telephone:		**Fax:**	

Disability Applicant Information:

	***-**-__ __ __ __
Applicant's Full Name (First, Middle Initial, Last)	**Social Security # (last four)**

Basis of Disability Retirement (Please describe):	
Type of Disability*:	

Enter **ONE** of the following: **ACCIDENTAL, ORDINARY, EITHER** (for Accidental or Ordinary), or **VIOLENT ACT INJURY**

*If you have questions about the disability retirement being sought, please contact your retirement board.

Employer Information:

Name of Dept./Agency:					
Name of Direct Supervisor:				**Title:**	
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Fax Number:**			
Email:					
Name of Department Head:				**Title:**	

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Applicant's Current Employment

1. Applicant's current job title:
2. Date employment began: Date employment ended:
3. Last date able to perform the essential duties of the position:
4. Is the position classified under Civil Service? ☐ YES ☐ NO
5. Please describe the essential duties that the applicant is required to perform in his or her current position (Please see the last page of this document for a definition of essential duties.)
6. How frequently is the applicant required to perform these essential duties?
7. Please describe the physical or mental requirements of the applicant's current position. (For example, how much lifting, bending, strength, etc. is necessary.)
8. Of the physical or mental requirements described above, are there any that the applicant cannot perform because of the claimed disability? ☐ YES ☐ NO
9. Is the applicant currently performing in an accommodated position? ☐ YES ☐ NO
   - If **YES,** attach the accommodated job description.
   - If **YES,** how long have they been in the accommodated position?
   - If **YES,** is this a temporary or permanent accommodation?
10. Could the applicant perform the essential duties of his or her current position if he or she was reasonably accommodated? ☐ YES ☐ NO
    - If the applicant is not in an accommodated position, are there any accommodated positions that the applicant could hold currently? ☐ YES ☐ NO
    - If **YES**, please explain:
11. Has this employee been officially investigated for or charged with misappropriation of funds from his/her employer or convicted of any crime related to his/her office or position? ☐ YES ☐ NO
    If **YES**, please provide documentation.

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Condition & Current Employment

1. Has the applicant's medical condition affected his or her attendance and job performance? If **YES,** please explain. ☐ YES ☐ NO

2. Did the applicant request any modification of job duties in order to accommodate his or her medical condition? If **YES,** please explain. ☐ YES ☐ NO

3. Has your department offered any modification of job duties or other reasonable accommodations to the applicant because of his or her medical condition? If **YES,** please explain. Attach the modified job description. ☐ YES ☐ NO

4. Did the applicant file any grievances or legal claims against your department that could be related to his or her claim for disability? If **YES,** please explain the status of any such grievance or claim. ☐ YES ☐ NO

5. Based on the applicant's claim of disability, has your department conducted any tests or studies on the building in which your department is located or the surrounding grounds? If **YES,** please explain. Attach any available documentation regarding tests or studies done. ☐ YES ☐ NO

6. Is the applicant's claimed disability the result of or in any way related to, a personnel action? If **YES,** please explain. ☐ YES ☐ NO

7. Is the applicant's claimed disability the result of any misconduct on his/her part? If **YES,** please explain. ☐ YES ☐ NO

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Circumstances Related to Claim of Accidental Disability

If you are aware of any Incidents or Hazards that are related to the applicant's job duties that may have caused or contributed to the applicant's claimed disability, provide information about them, in as specific a manner as possible, in the following section. Please attach any Injury or Incident reports regarding the claimed disability filed by this applicant. If the space provided proves to be insufficient, you may attach additional sheets to this document. If you are not aware of any such job related Incidents or Hazards, skip this section.

One of the conditions for receiving approval of an application for accidental disability retirement benefits is that the retirement board must find that the applicant's disability is the natural and proximate result of either:

- A personal injury sustained (usually, one or several specific incidents) or
- A hazard undergone (generally, exposure to a harmful situation over a period of time).

Occurrence #1

Incident or Hazard Related to the Applicant's Job Duties

Date of occurrence	Time	Location

Description of Incident or Hazard

Witness Data Related to Occurrence #1 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the Incident or Hazard (related to the applicant's job duties) described above. Attach additional sheets if necessary.

Witness 1:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			
Witness 2:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Circumstances Related to Claim of Accidental Disability *(Continued)*

Occurrence #2

Incident or Hazard Related to the Applicant's Job Duties

Date of occurrence	Time	Location

Description of Incident or Hazard

Witness Data Related to Occurrence #2 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the Incident or Hazard (related to the applicant's job duties) described above. Attach additional sheets if necessary.

Witness 1:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			
Witness 2:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Other Contributing Circumstances

Are you are aware of any Incidents or Hazards that are not related to the applicant's job duties that may have caused or contributed to the applicant's claimed disability?

- If so, provide information about them in the following section.
- If you are not aware of any such non-job related Incidents or Hazards, skip this section.

Occurrence #1

Incident or Hazard NOT Related to the Applicant's Job Duties

Date of occurrence	Time	Location

Description of Incident or Hazard NOT related to the Applicant's Job Duties

Witness Data Related to Occurrence of an Incident or Hazard NOT Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the Incident or Hazard (related to the applicant's job duties) described above.

Witness 1:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			
Witness 2:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip Code:**	
Phone Number:		**Email:**			

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Violent Act Injury Disability

Added to the retirement law in 2024, G.L. c. 32, §§ 1 and 7 establish an enhanced accidental disability retirement benefit, known as the Violent Act Injury Disability benefit, for certain members who suffer catastrophic, life-threatening or life-altering permanent bodily injuries as a result of a violent physical attack by means of a dangerous weapon, which is designed for the purpose of causing serious injury or death, including, but not limited to, a firearm, knife, automobile or explosive device. Psychological injuries are not eligible for Violent Act Injury Disability benefits.

Answer ONLY if the Applicant is Applying for Violent Act Injury Disability

1. **Injury:** ☐ YES ☐ NO
   Did the applicant sustain a catastrophic, life-threatening or life-altering, permanent bodily injury?
   If **YES,** please describe such injury:

2. **Violent Physical Attack:** ☐ YES ☐ NO
   Was said injury the direct and proximate result of a violent and intentional physical attack upon the applicant?
   If **YES,** please provide the following:
   a. The date of the attack:
   b. The location of the attack:
   c. The names of any witnesses:
   d. The details of the attack:

3. **Dangerous Weapon:** ☐ YES ☐ NO
   Was the attack by means of a dangerous weapon designed for the purpose of causing serious injury or death?
   If **YES,** please identify the weapon below:

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Early Intervention Plan

1. Has the applicant been offered an early intervention plan pursuant to Massachusetts General Laws, Chapter 32, Section 5B? ☐ YES ☐ NO
2. Has the applicant failed to participate in the assessment or required rehabilitation of an early intervention plan pursuant to Massachusetts General Laws, Chapter 32, Section 5B? ☐ YES ☐ NO

Workers' Compensation (Related to the Applicant's Claimed Disability)

1. Has the applicant applied for Workers' Compensation benefits for this claimed disability? ☐ YES ☐ NO
   If **YES,** please provide the date of application:
2. Has the applicant received or is he/she now receiving Workers' Compensation benefits for this claimed disability? If **YES**, please provide the following information: ☐ YES ☐ NO
   - Date weekly payments commenced:
   - Amount of initial weekly payments:
   - Amount of current weekly payment:
   - Date payments terminated, if relevant:
   - Did the Treasurer/DIA construct a rehabilitation plan in the course of the applicant's Workers' Compensation claim? If **YES,** please provide the documentation. ☐ YES ☐ NO
3. Has the applicant received a Workers' Compensation settlement for this claimed disability? ☐ YES ☐ NO
   If **YES**, record the date the settlement was awarded:
4. Contact person for workers compensation:

   Email: Phone Number:

Section 111F Benefits (Related to the Applicant's Claimed Disability)

1. Has the applicant received or is he or she receiving benefits pursuant to Massachusetts General Laws, Chapter 41, Section 111F? ☐ YES ☐ NO

   If **YES**, please provide dates for the periods during which Section 111F benefits are or were being paid:

Assault Pay (Related to the Applicant's Claimed Disability)

1. Has the applicant received or is he or she receiving assault pay pursuant to Massachusetts General Laws, Chapter 126, Section 18A? ☐ YES ☐ NO

   If **YES**, please provide dates for the periods during which assault pay is or was being paid:

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Required Signatures

I, the undersigned, have been authorized by the department/agency listed on page 1 to prepare this statement. I understand that the above named applicant has applied for disability retirement pursuant to the provisions of Massachusetts General Laws Chapter 32. I certify that I have read and understand the information contained in this statement, and I subscribe, under the penalties of perjury, that the information I have supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Direct Supervisor (Print):

Signature of Direct Supervisor: **Date:**

I, the undersigned, have been authorized by the department/agency listed on page 1 to counter sign this statement. I certify that I have read and understand the information contained in this statement, and I subscribe, under the penalties of perjury, that the information supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Department Head (Print):

Signature of Department Head: **Date:**

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Determination of Essential Duties

In connection with all applications for disability retirement and evaluations, a determination of the essential duties of the relevant job or position shall be made.

The determination of what constitutes an essential duty of a job or position is to be made by the employer, based on all relevant facts and circumstances and after consideration of a number of factors.

Please note that if the Commonwealth's Human Resources Division has promulgated a list or description of essential duties for a position that is consistent with those of the member's position, the employer shall submit such a list or description as the essential duties for the position in question.

The telephone number of the Commonwealth's Human Resources Division is 617-878-9700. Their website address is www.mass.gov/hrd. It is anticipated that job specifications will be posted there. The term "essential duties" as used in Massachusetts General Laws, Chapter 32 and in all regulations promulgated by the Public Employee Retirement Administration Commission shall mean those duties or functions of a job or position which must necessarily be performed by an employee to accomplish the principal objective(s) of the job or position. The essential duties of a position are those that bear more than a marginal relationship to the position.

In making the determination as to whether a function or duty is essential, the employer shall consider and provide documentation to include, but not be limited to:

- The nature of the employer's operation and the organizational structure of the employer;
- Current written job descriptions;
- Whether the employer requires all employees in a particular position to be prepared to perform a specific duty;
- The number of employees available, if any, among whom the performance of the job function can be distributed;
- The amount of time that employees spend performing the function;
- Whether the function is so highly specialized that the person in the position was hired for his or her special ability to perform the function;
- The consequences of not requiring the employee to perform the function;
- The actual experience of those persons who hold and have held the position or similar positions; and
- Collective bargaining agreements.

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Addendum Sheet to the Employer's Statement Pertaining to Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.