PERA
Public Employees
Retirement Association
of New Mexico

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(505) 476-9401 fax (505) 476-9300 voice
(800) 342-3422 Toll-Free
www.nmpera.org

EMPLOYER'S REPORT OF DISABILITY FORM

Instructions: Please print or type in dark ink. The original of this form must be completed in its ENTIRETY and returned to PERA for processing. Required Fields are in *BOLD ITALICS*

The member named below is applying for PERA disability retirement. To be considered, PERA must receive this completed report on him/her. In addition, please send a copy of all accident reports and worker's compensation reports (if applicable) filed with your agency relating to injury or illness and any others that may have occurred in the past.

***Please also provide a copy of the member's job description.**

Please type or print so that others can read this information. Attach additional sheet(s) if necessary.

1. ***Name of Claimant*** _____

2. ***Social Security Number*** | | | | – | | | – | | | | |

3. ***Current or Last Employer*** _____

4. ***Position or Job Title*** _____

5. ***Current Employment Status*** ☐ Not Working Date Terminated _____
(please select one)
Date Resigned _____
Effective Date of Leave Without Pay _____
Effective Date of Worker's Comp _____

☐ Working ☐ Full time ☐ Part time
☐ Sick leave ☐ On Worker's Comp
☐ Annual leave

6. Is employee currently performing his/her regular job duties? ☐ Yes ☐ No
7. ***IF YES***, what are the employee's regular job duties? _____
_____
8. ***IF NO***, have his/her job duties been modified? ☐ Yes ☐ No
9. ***IF YES***, what are his/her current job duties? _____
_____
_____
10. Was the employee performing his/her regular job duties at the time of injury or illness? ☐ Yes ☐ No
11. Date of injury or illness _____

Name of Claimant_____ ***Social Security No***._____

12. Do you consider this to have occurred as the natural and proximate result of causes arising solely and exclusively out of and in the course of his/her employment? ☐ Yes ☐ No
13. If yes, why? _____
    _____
14. When were you first informed of the injury or illness?
15. Has the employee applied for Workers' Compensation? ☐ Yes ☐ No
16. ***IF YES***, when did he or she apply? _____
17. Has the employee been approved? ☐ Yes ☐ No
18. ***IF YES***, what is the amount of the benefits? _____
19. Did the employee receive a lump sum settlement? ☐ Yes ☐ No
20. ***IF YES***, what is the amount of the settlement? _____
21. Describe the status of the employee's Workers' Compensation claim.

_____

_____

_____

By my signature, I declare that all information given is true and correct to the best of my knowledge and belief.

_____ _____
Authorized Signature (Supervisor) ***Title***

_____
Phone Number

_____ _____
Name of Employer ***Date***

Please attach any medical, accident Workers' Compensation reports relating to the claimant.