

REPORT OF PUBLIC SAFETY OFFICERS' PERMANENT AND TOTAL DISABILITY

[System Help](#) | [Application Help](#)

Use Question Number tabs below to navigate through the form.

1 - 5 | 6 - 8 | 9 - 11 | 12 | 13 | 14 - 15

*** Required Field**

1. NAME, ADDRESS, AND TELEPHONE NUMBER OF DISABLED OFFICER

First *

Middle

Last *

Address *

City *

State *

ZIP Code * (00000 or 00000-0000)

Contact Information * (Either a telephone number or email address is required) 

Home Phone (000-000-0000)

Day Phone Ext
(000-000-0000 Ext 00000)

Cell Phone (000-000-0000)

E-mail

2. SOCIAL SECURITY NUMBER * (000-00-0000)

3. DATE OF BIRTH * (mm/dd/yyyy)

4. DATE OF INJURY * (mm/dd/yyyy)

5. STATEMENT ON OTHER CLAIMS FILED WITH THE UNITED STATES GOVERNMENT AND/OR THE DISTRICT OF COLUMBIA: Claim has been filed for benefits under 

A) Federal Employees Compensation Act, Section 8191 Title 5, U.S. Code? * Yes No

B) D.C. Retirement and Disability Act of September 1, 1916, Section 4-622? * Yes No

[Checklist for Filing a PSOB Disability Claim](#)

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[System Help](#) | [Application Help](#)

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6. NAME AND MAILING ADDRESS OF PUBLIC SAFETY AGENCY, ORGANIZATION OR UNIT IN WHOSE SERVICE THE INJURY OCCURRED 

Name of Employing Agency *

Address *

City *

State *

ZIP Code * (00000 or 00000-0000)

7. NAME OF DISABLED OFFICER'S SUPERIOR OFFICER 

First *

Middle

Last *

8. TELEPHONE NO. OF SUPERIOR OFFICER *  (000-000-0000)

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[System Help](#) | [Application Help](#)

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-

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9. PLEASE SELECT THE OFFICER'S EMPLOYMENT STATUS WHEN INJURY OCCURRED * 

Full-Time Part-Time Volunteer Other(Specify)

10. PLEASE ATTACH ALL APPLICABLE REPORTS RELATING TO THE DIRECT CAUSE OF THE PERMANENT AND TOTAL DISABILITY. PROVIDE A CERTIFIED COPY OF ORIGINAL REPORTS. * 

Examples are CIRCUMSTANCES OF INJURIES, MEDICAL DOCUMENTATION, AGENCY INVESTIGATION REPORTS, OFFICIAL TOXICOLOGY REPORTS, OTHER.

[Attach Documents](#) 

11. AT THE TIME OF THE INJURY THAT CAUSED THE PERMANENT AND TOTAL DISABILITY WAS THE OFFICER

WORKING A REGULAR SHIFT? * AN OVERTIME SHIFT? OR OFF DUTY?

IF OFF DUTY, PLEASE ATTACH THE RULES, REGULATION OR LAW AUTHORIZING OR OBLIGATING THE OFFICER TO ACT IN THE LINE OF DUTY OUTSIDE OF SCHEDULED DUTY HOURS. *

[Attach Documents](#) 

AS A: *

- Police Officer
- Corrections Officer
- Probation Officer
- Parole Officer
- Firefighter
- Ambulance and Rescue Squad Member
- Other (Specify)

IN THE SERVICE OF: *

- State Government
- Local Unit of Government
- Federal Government
- Legally organized volunteer fire, ambulance or rescue squad department organized, chartered or formed by a public safety agency to act on its behalf in providing fire or rescue service to the public
- Other (Specify)

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- 1 - 5
6 - 8
9 - 11
12
13
14 - 15

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12. WAS THE OFFICER'S INJURY THE RESULT OF:

	YES	NO	UNKNOWN
Gross negligence? *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intentional misconduct? *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Intent to bring about own injury? *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Voluntary intoxication? *	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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1 - 5 6 - 8 9 - 11 12 **13** 14 - 15

13. IF KNOWN, GIVE NAME AND ADDRESS OF WITNESS(ES) TO THE OFFICER'S INJURY IF NOT PROVIDED IN INVESTIGATIVE REPORTS. 

First	<input type="text"/>
Middle	<input type="text"/>
Last	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="Select a State or Territory"/>
ZIP Code	<input type="text"/> (00000 or 00000-0000)

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Certifications: A false answer to any question in this Statement may be grounds for non-payment of benefits and may be punishable by fine or imprisonment (U.S. Code, Title 18, Sec. 1001). All the information you give will be considered in reviewing the claim and is subject to investigation.

14. EMPLOYING ORGANIZATION - To the best of our knowledge and belief, the above information is factual and complete.

Name and Title of Employing Agency Head *
(Commissioner, Chief, Sheriff, Warden, etc.)

Phone No. *

(000-000-0000)

Date *

(mm/dd/yyyy)

Signature of Employing Agency Head *

Checking this box asserts that all of the information you have provided on this form is true and correct, and will be treated as an electronic signature by the applicant.

15. Acknowledgment of Disabled Officer or Authorized Representative (If representative, provide officer's affidavit granting power of attorney) * ?

The acknowledgment may be in the form of an attached letter, email, or other documentation that clearly indicates the officer or authorized representative has approved the submittal of this form on his or her behalf.

[Attach Documents](#)



Checking this box asserts that you as agency head have received the officer's or the authorized representative's acknowledgment. *

Date *

(mm/dd/yyyy)

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