



State of New Jersey • Department of the Treasury
DIVISION OF PENSIONS & BENEFITS — RETIREMENT SECTION
 P.O. Box 295, Trenton, NJ 08625-0295
COVID-19 MEDICAL QUESTIONNAIRE

In order to process your application for Accidental Disability retirement in accordance with Chapter 54, P.L. 2020, you must complete this form in its entirety and provide all requested documents not limited to, but including; an accident report, copy of positive COVID-19 test results, written documentation from a licensed health care provider indicating you are totally and permanently disabled as a result of your exposure to COVID-19 during work related duties that require interaction with the public during a Public Health Emergency declared by the Governor in Executive Order 103, of 2020, as extended within 14 days of showing symptoms consistent with COVID-19.

PART 1 — MEMBER INFORMATION

Select Retirement System SPRS PERS First Responders Membership Number _____

Name _____
 Last First Middle

PART 2 — COVID-19 QUESTIONNAIRE

What was the date and location of the COVID-19 exposure that led to your alleged total and permanent disability?

Date ____/____/____ Location _____

Was a report of the incident filed with your employer? Yes No

If yes, list your immediate supervisor, date the report was filed, report number if any, and provide a copy of the report.

Supervisor’s Name _____

Date Filed ____/____/____ Report Number _____

Were you tested for COVID-19 in New Jersey or any other state? Yes No

If yes, list the date(s), location(s), and results of all tests. Provide a copy of positive test results for SARS-CoV-2.

Date ____/____/____ Location _____ Results _____

Date ____/____/____ Location _____ Results _____

Please provide a copy of the work schedule or timesheet for the two weeks prior to receiving a positive test result for SARS-CoV-2.

Did you have a prescription for testing? Yes No

If yes, provide the name, address and phone number for the issuing physician.

Physician Name _____ Phone Number _____

Address _____
 Street City State Zip Code

Were you hospitalized for treatment of COVID-19? Yes No

If yes, provide the hospital name and address, date of admission, and length of stay for any of the above noted positive tests.

Hospital Name _____

Address _____
 Street City State Zip Code

Admission Date ____/____/____ Discharge Date ____/____/____

PART 3 — MEDICAL HISTORY

List all medical conditions for which you see a doctor _____

Provide the name, address and phone number for each pharmacy you use _____

Who is your Primary Care Physician?

Physician Name _____ Phone Number _____

Address _____
Street City State Zip Code

Provide information for all physicians who have treated you within the last five years, and the medications they prescribed you, including dosage and frequency. Additional physician or prescription information can be printed and attached to this document.

Physician Name _____ Specialty _____

Address _____ Phone Number _____

List medications and pharmacy where filled _____

Physician Name _____ Specialty _____

Address _____ Phone Number _____

List medications and pharmacy where filled _____

PART 4 — SIGNATURE

Fraud Warning - Any person who knowingly submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an application for disability retirement benefits or a statement of claim for payment of a benefit, commits a fraudulent act and is guilty of a crime and may be subject to punishment.

I hereby certify that the information I have provided on this form is accurate to the best of my knowledge and that I have read, understand and agree with the fraud warning statement.

Member Signature _____ *Date* _____

If someone other than the member has completed this form, please print your name, your relationship to the member, your phone number, and your signature.

Print Name Relationship to Member Phone Number

Signature _____ *Date* _____

You may scan this document and its attachments and email to: **disabilityrets@treas.nj.gov**