LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS DISABILITY BENEFITS TRUST FUND
PROPOSED POLICIES AND PROCEDURES
JULY 1, 2006

I. PURPOSE

The Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund (herein referred to as "the Fund") was created by the Mississippi Legislature to provide disability benefits to law enforcement officers and fire fighters injured in the line of duty. These benefits shall be payable for the period of time the covered individual is physically unable to perform the duties of his or her employment [not to exceed twelve (12) total payments for any one (1) injury].

The Fund originated at the Mississippi Department of Public Safety and came under the purview of the Mississippi Attorney General's Office on July 1, 2006, pursuant to Section 45-2-21, Mississippi Code Annotated (1972).

II. DEFINITIONS

"Law enforcement officer" means any lawfully sworn officer or employee of the state or any political subdivision of the state whose duties require the officer or employee to investigate, pursue, apprehend, arrest, transport or maintain custody of persons who are charged with, suspected of committing, or convicted of a crime.

"Fire fighter" means an individual who is trained for the prevention and control of loss of life and property from fire or other emergencies, who is assigned to fire-fighting activity, and is required to respond to alarms and perform emergency actions at the location of a fire, hazardous materials or other emergency incident.

"Covered individual" means a law enforcement officer or fire fighter (as defined above) while actively engaged in protecting the lives and property of the citizens of this state when employed by an employer as defined below. Employees of independent contractors are not included in this definition.

"Employer" means a state board, commission, department, division, bureau, or agency, or a county, municipality or other political subdivision of the state, which employs, appoints or otherwise engages the services of covered individuals.

III. ELIGIBILITY

Any actively employed law enforcement officer or fire fighter who is accidentally or intentionally injured in the line of duty as the direct result of a single incident is eligible to receive benefits.

III. ELIGIBILITY (continued)

The individual must be employed by a state board, commission, department, division, bureau, or agency, or a county, municipality, or other political subdivision of the state. Employees of independent contractors are not eligible.

IV. EXCLUSIONS

Chronic or repetitive injury is not covered.

Section 45-2-21, Mississippi Code Annotated (1972) states, "Compensation under this section shall not be awarded where a penal violation committed by the covered individual contributed to the disability or the injury was intentionally self-inflicted."

V. EXEMPTION FROM CREDITORS

"Payments made from the Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund are exempt from the claims and demands of creditors of the covered individual" per Section 45-2-21, Mississippi Code Annotated (1972).

VI. OBTAINING PROGRAM INFORMATION

Applications are included in these policies and procedures as **EXHIBIT A**. Also, applications and instructions can be obtained from the following sources:

Website: www.ago.state.ms.us

Mail: Mississippi Attorney General's Office
Law Enforcement Officers and
Fire Fighters Disability Benefits Trust Fund
P. O. Box 220
Jackson, MS 39205

Phone: (601) 359-3810

Applications for benefits must be submitted to the Mississippi Attorney General's Office at the mailing address listed above.

VII. APPLICATION/APPROVAL PROCESS

Upon receipt of the application, information on the application is reviewed/investigated to insure validity of the claim for benefits. If the application for benefits is approved

VII. APPLICATION/APPROVAL PROCESS (continued)

[based on the criteria stipulated in these policies and procedures and Section 45-2-21 of the Mississippi Code Annotated (1972)], a letter is sent via certified mail to the applicant indicating the approval of benefits, the amount of benefits to be awarded, the number of payments to be awarded, and the method of payment.

If the application for benefits is denied, a letter is sent via certified mail to the applicant including the grounds for denial of the application.

Applicants who disagree with any decision made have the right to appeal within thirty (30) days of receipt of the letter approving or denying benefits. For further information on the appeals process, see section XV.

Applications must be filed with the Mississippi Attorney General's Office within six (6) months of the date of injury.

Compensation shall not be awarded unless the incident of injury occurred on or after July 1, 2006.

VIII. BENEFIT PAYMENTS

Once the application is approved, the Mississippi Attorney General's Office will make a monthly disability benefit payment equal to thirty-four percent (34%) of the covered individual's regular base salary at the time of injury. The benefit is payable for the period of time the covered individual is physically unable to perform the duties of his or her employment [not to exceed twelve (12) total payments for any one (1) injury]. The physician's report (which is included in the application for benefits) will document the dates the applicant is unable to work and the anticipated return to work date.

Benefit payments will be mailed to the covered individual on the first working day of each calendar month. Benefit payments from the Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund are excluded from gross income and thus are not taxable.

IX. WORKERS' COMPENSATION

If the covered individual receives workers' compensation benefits in addition to benefits from the Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund, then payments from the Fund will be **limited to the difference between workers' compensation benefits and the amount of the covered individual's regular base salary**.

X. CONFIDENTIALITY OF RECORDS

It is unlawful, except for purposes directly connected with the administration of the fund, for any person to solicit, disclose, receive or make use of or authorize, knowingly permit, participate in or acquiesce in the use of any list, or names of, or information concerning persons applying for or receiving awards under this chapter without the written consent of the claimant or recipient. The records, papers, files and communications of the staff administering the fund must be regarded as confidential information and privileged and are subject to the Mississippi Public Records Act of 1983.

XI. OVERPAYMENT OF BENEFITS

If a payment or overpayment of benefits is made due to clerical error, mistaken identity, or innocent misrepresentation by or on behalf of the covered individual, the covered individual is responsible for repayment of the benefits received.

XII. FALSE INFORMATION

The filing of a false application for benefits (i.e., fraudulent or false information is knowingly submitted and/or failure to disclose pertinent information) is unlawful. In addition to any criminal penalties, the Mississippi Attorney General's Office shall have a right to commence civil action for the recovery of benefits obtained by the covered individual upon filing a false application. In such cases, the defendant shall be responsible for the fees, court costs, and other expenses of litigation.

XIII. REDUCTION OF BENEFIT PAYMENTS

Not withstanding any other provisions herein, no benefit payments shall be made unless adequate funds are available in the Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund. The State shall not be liable for a written order to pay compensation, except to the extent that monies are available in the fund on the date the claim is approved. The Mississippi Attorney General's Office has the right to adjust benefit payments so that the total amount awarded does not exceed the amount of money on deposit in the fund. During the approved benefit period when such reduction is due to the unavailability of funds, covered individuals may not seek future reimbursements due to any reductions in benefit payments. The Mississippi Attorney General's Office may opt to suspend payments until sufficient funding is on deposit in the fund.

XIV. EMPLOYER RESPONSIBILITIES

The covered individual's employer is responsible for completing the "Employment Information" section of the application for benefits. In addition, the employer is required

XIV. EMPLOYER RESPONSIBILITIES (continued)

to send written notice in the format prescribed by the Mississippi Attorney General's Office notifying the Fund Administrator the exact date the employee returned to work. This written notice must be submitted no later than ten (10) working days after the employee returns to work. See format for "Employee Return to Work Letter" at **EXHIBIT B**.

XV. APPEALS

If the claim is denied for any reason, the applicant has the right to appeal within thirty (30) days of receipt of the letter denying benefits. The appeal process consists of two steps: reconsideration and a contested hearing.

Reconsideration is intended to be an informal resolution of a claim. If the applicant disagrees with the original determination, he or she may request reconsideration through the Director of Administration at the Mississippi Attorney General's Office.

If the applicant disagrees with the decision of reconsideration, he or she may request a contested hearing within fifteen (15) days of the decision of reconsideration before a committee. The committee consists of three (3) members appointed by the Attorney General. This hearing is informal; however, the applicant must appear in person at the hearing, and a record of the hearing is made. The decision made by the committee is the final decision of the Mississippi Attorney General's Office.

XVI. RE-CERTIFICATION OF BENEFITS

If a covered individual returns to work based on his or her physician's recommendation in the application for benefits and it is later determined the employee is still unable to perform his or her duties, the covered individual may apply for a re-certification of benefits. The covered individual must have his or her employer and physician complete the Application for Re-Certification of Benefits to extend the period the covered individual is unable to work. This period should begin on the last date worked (note: this date will be different from the date on the initial application for benefits). See **EXHIBIT C**. This application must be submitted as described in Section VI.

EXHIBIT A

For MS Attorney General's Office Use Only:	
Application #:	**Receipt Date:**
Approved **Disapproved**	**Claim type:** **Law Enforcement Officer** **Fire Fighter**

APPLICATION FOR BENEFITS
LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS DISABILIITY BENEFITS TRUST FUND

Mail to: **MISSISSIPPI ATTORNEY GENERAL'S OFFICE**
c/o Law Enforcement Officers & Firefighters Disability Benefits Trust Fund
P.O. Box 220
Jackson, MS 39205-0220

A. APPLICANT INFORMATION. To be completed and signed by the APPLICANT:

Applicant's Name: _____ SSN: _____

Date of Birth (mm/dd/yyyy): _____ Gender: Male Female

Street Address _____
Street (Apt. #) City State Zip Code

Mailing Address _____
City State Zip Code

Employer Name and Address: _____
_____

Date of Injury: _____/_____/_____ Time of Injury: _____ am/pm (circle one)

Tell us how your injury occurred:
_____
_____
_____
_____
_____

Were you acting in the line of duty at the time of the incident? Yes No

Have you previously had the same/similar injury? _____ If so, when? _____

Have you filed, or do you plan to file, for Workers' Compensation? Yes No

APPLICANT NAME _____ **SSN** _____

A. APPLICANT INFORMATION (continued). To be completed and signed by the APPLICANT:

Physician/Healthcare Provider Information:

Physician Name: _____

Mailing Address: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of this application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

_____ _____

Applicant's Signature **Date (mm/dd/yyyy)**

If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.)

_____ _____ _____

Printed name of legal representative **Signature of legal representative** **Date (mm/dd/yyyy)**

APPLICANT NAME _____ **SSN** _____

B. PHYSICIAN'S CERTIFICATION. To be completed and signed by the PHYSICIAN treating you for this disability:

Diagnosis/primary disabling condition:_____

Has this patient been treated for the same/similar condition prior to this occurrence? If so, list related diagnoses & dates of treatment:_____
_____

Is this patient temporarily disabled? Yes No If yes, what are the temporary restrictions/limitations? _____
_____

Anticipated return to work/release date: _____ If undetermined, based on your medical knowledge, what is a reasonable timeframe before you expect to be able to release this patient to return to work?

Dates unable to work: Partial Duty: From _____/_____/_____ To: _____/_____/_____

Dates unable to work: Full Duty: From _____/_____/_____ To: _____/_____/_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the patient's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

Signature of doctor: _____ **Date (mm/dd/yyyy)**_____

Name of doctor: _____ Phone: (_____)_____

Fax: (_____)_____ **Tax ID or SSN:** _____

Address: _____

Email address: _____ **Patient #:** _____

NOTE: Please make a copy of the patient's signed Authorization for Release of Records (Section D) for your records.

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION. To be completed and signed by your EMPLOYER.

Name of Employer: _____ Phone Number (_____)_____

Mailing Address_____

Email address:_____ Fax Number: (_____)_____

Employee's Job Title: _____

For the purposes of determining eligibility for benefits, Section 45-2-21, Mississippi Code Annotated (1972) sets forth the following definitions:

"Fire fighter" means an individual who is trained for the prevention and control of the loss of life and property from fire or other emergencies, who is assigned to firefighting activity, and is required to respond to alarms and perform emergency actions at the location of a fire, hazardous materials or other emergency incident.

"Law enforcement officer" means any lawfully sworn officer or employee of the state or any political subdivision of the state whose duties require the officer or employee to investigate, pursue, apprehend, arrest, transport or maintain custody of persons who are charged with, suspected of committing, or convicted of a crime.

This employee _____ does _____ does not (check one) meet the criteria of one of the above definitions.

Average hours per week the employee worked prior to this incident: _____ hours/week

Monthly salary $ _____ Annual Salary $ _____

For the last full pay period worked, please include the following information:

Pay Period (mm/dd/yyyy): From _____/_____/_____ To _____/_____/_____

Base Wages: _____ Overtime Wages: _____

Last work date: _____

Has the employee returned to work? Yes No If yes, date employee returned to work:_____

APPLICANT NAME _____ **SSN** _____

C. EMPLOYMENT INFORMATION (continued). To be completed and signed by your EMPLOYER.

Has Workers' Compensation been applied for? Yes No Approved? Yes No

Name and address of Workers' Compensation carrier:

_____

_____

Is this condition the result of an accidental or intentional injury received in the line of duty as the result of a single incident? Yes No

If yes, please provide us with the date and description:

_____

_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the employee's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information. ***Furthermore, I will notify the Mississippi Attorney General's Office in writing the exact date the employee returns to work. This notification shall be submitted no later than ten (10) days after the employee returns to work in the format prescribed by the Mississippi Attorney General's Office.***

_____ _____ _____

Signature of Employer **Job Title** **Date (mm/dd/yyyy)**

NOTE: Please make a copy of the employee's signed Authorization for Release of Records (Section D) for your records.

APPLICANT NAME _____ **SSN** _____

D. AUTHORIZATION FOR RELEASE OF RECORDS. To be completed by APPLICANT.

For the purpose of evaluating my eligibility for benefits including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application, I hereby authorize the disclosure of information from my physician/healthcare provider and from my Employer to the Mississippi Attorney General's Office or its authorized representatives.

Health information may be disclosed by any physician or healthcare provider that has any records or knowledge about the incident referred to on this application. Non health information including earnings or employment history or any other facts deemed appropriate by the Mississippi Attorney General's Office or its authorized representatives to evaluate my application may be disclosed by any entity, person, or organization that has records about me, including but not limited to my employer, employer representative and compensation sources.

Any information the Mississippi Attorney General's Office or its authorized representatives obtain pursuant to this authorization will be used only for the purpose of evaluating and administering my application for benefits. The Mississippi Attorney General's Office or its authorized representatives will not disclose any information unless permitted by federal and/or state laws. I further authorize the Mississippi Attorney General's Office to notify my employer of any benefits received and any employer responsibilities as related to my claim.

This authorization is valid for two (2) years from its execution, and a copy is as valid as the original. I know that I may request a copy of this authorization to request this information. This authorization may be revoked by me at any time except to the extent the Mississippi Attorney General's Office or its authorized representatives has relied on the authorization prior to notice of revocation. If revoked, the Mississippi Attorney General's Office or its authorized representatives may not be able to evaluate my application for benefits. I may revoke this authorization by sending written notice to: Mississippi Attorney General's Office, c/o Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund, P. O. Box 220, Jackson, MS 39205.

You may refuse to sign this form; however, the Mississippi Attorney General's Office or its authorized representatives will not be able to evaluate your application or administer your claim for benefits. I am the individual to whom this authorization applies or that person's legal representative.

_____	_____
Printed name of individual subject to this disclosure	**Social Security Number**
_____	_____
Signature	**Date (mm/dd/yyyy)**

If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.

_____	_____	_____
Printed name of legal representative	**Signature of legal representative**	**Date (mm/dd/yyyy)**

STATE OF MISSISSIPPI

COUNTY OF

Personally came and appeared before me, the undersigned authority in and for said county and state, the within named _____, who acknowledged to me that he signed and delivered the above forgoing waiver on the date therein mentioned and for the purpose therein expressed.

Given under my hand and seal of office, this _____ day of _____, _____.

_____ **NOTARY PUBLIC**

My Commission Expires:

APPLICANT NAME _____ **SSN** _____

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__ - _______

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Cat. No. 10231X Form W-9 (Rev. 11-2005)

Example of Employee Return to Work Letter **EXHIBIT B**

LETTER SHOULD BE TYPED ON EMPLOYER'S LETTERHEAD

CURRENT DATE

Mississippi Attorney General's Office
c/o Law Enforcement Officers and Fire Fighters
Disability Benefits Trust Fund
P. O. Box 220
Jackson, MS 39205-0220

Re: **EMPLOYEE NAME AND SSN**

Dear Fund Administrator:

As part of the policies and procedures of the Law Enforcement Officers and Fire Fighters Disability Benefits Trust Fund, **(EMPLOYER NAME)** is required to notify the Mississippi Attorney General's Office when (**NAME OF EMPLOYEE**) returns to work. As of (**DATE EMPLOYEE RETURNED TO WORK**), (**EMPLOYEE NAME**) returned to his/her official employment duties on a **part-time/full-time** *(select one)* basis and from this day forward will be receiving compensation for these duties. I certify **(EMPLOYEE NAME)** will be receiving **(COMPENSATION AMOUNT)** per **hour/week/month** *(select one). Insert the last sentence only if the employee is returning on a part-time basis:* I will promptly notify the Mississippi Attorney General's Office when **(EMPLOYEE NAME)** returns to work on a full-time basis.

Sincerely,

_____
(SIGNATURE AND TITLE OF EMPLOYER REPRESENTATIVE)

Note: Employer must use this format when reporting the employee's return to work date. Information in bold print should be filled in by the employer for the applicable employee. Letter should be typed on Employer's Letterhead.

EXHIBIT C

MS Attorney General's Office Use Only:	
Original Claim #:	**Receipt Date:**
□ Approved □ Denied	**Claim type: □ Law Enforcement Officer □ Fire Fighter**

APPLICATION FOR RE-CERTIFICATION OF BENEFITS LAW ENFORCEMENT OFFICERS AND FIRE FIGHTERS DISABILITY BENEFITS TRUST FUND

Mail to: **MISSISSIPPI ATTORNEY GENERAL'S OFFICE**
c/o Law Enforcement Officers & Fire Fighters Disability Benefits Trust Fund
P.O. Box 220
Jackson, MS 39205-0220

Comment [Watermark1]: ... [1]

A. APPLICANT INFORMATION. To be completed and signed by the APPLICANT.

Applicant's Name: _____ SSN: _____

Date of Birth (mm/dd/yyyy): _____ Gender: □ Male □ Female

Street Address: _____
Street (Apt. #) City State Zip Code

Mailing Address: _____
City State Zip Code

Employer Name and Address: _____
_____

Original Date of Injury: _____/_____/_____

Dates applicant worked after being released by the physician to return to work:

From _____/_____/_____ To: _____/_____/

Have you re-filed, or do you plan to re-file, for Workers' Compensation? □ Yes □ No

A. APPLICANT INFORMATION (continued). To be completed and signed by the APPLICANT:

Physician/Healthcare Provider Information:

Physician Name: _____

Mailing Address: _____

Phone Number: (____) _____ Fax Number: (____) _____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of this application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

_____ _____

Applicant's Signature **Date (mm/dd/yyyy)**

If applicable, I signed on behalf of the applicant as legal representative. (Please attach a copy of documentation authorizing legal representation.)

_____ _____ _____

Printed name of legal representative **Signature of legal representative** **Date (mm/dd/yyyy)**

B. EMPLOYMENT INFORMATION. To be completed and signed by your EMPLOYER.

Name of Employer:_____ Phone Number (____)_____

Mailing Address: _____

Email Address: _____Fax Number: (____)_____

Employee's Job Title: _____

Monthly salary $ _____ Annual Salary $ _____

For the last full pay period worked, please include the following information:

Pay Period (mm/dd/yyyy): From _____/_____/_____ To _____/_____/_____

Base Wages: _____ Overtime Wages: _____

Dates employee worked after returning from injury leave period:

From _____/_____/_____ **To:** _____/_____/

Has Workers' Compensation been re-applied for? □ Yes □ No Approved? □ Yes □ No
Name and address of Workers' Compensation carrier:

_____

_____

Is this the same condition reflected in the original claim? □ Yes □ No

If yes, what are the restrictions/limitations preventing the employee from performing his or her regular duties: _____

_____

_____

_____

B. EMPLOYMENT INFORMATION (continued). To be completed and signed by your EMPLOYER.

Certification: I certify that the employment information in Section B is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the employee's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information. ***Furthermore, I will notify the Mississippi Attorney General's Office in writing the exact date the employee returns to work. This notification shall be submitted no later than ten days after the employee returns to work in the format prescribed by the Mississippi Attorney General's Office.***

Signature of Employer	Job Title	Date (mm/dd/yyyy)

C. PHYSICIAN'S CERTIFICATION. To be completed and signed by the PHYSICIAN treating you for this disability.

Diagnosis/primary disabling condition:_____

Original dates unable to work:

Partial Duty: **From** ____/____/____ **To:** ____/____/____

Full Duty: **From** ____/____/____ **To:** ____/____/____

Revised dates unable to work:

Partial Duty: **From** ____/____/____ **To:** ____/____/____

Full Duty: **From** ____/____/____ **To:** ____/____/____

Anticipated return to work/release date:_____ If undetermined, based on your medical knowledge, what is a reasonable time frame before you expect to be able to release this patient to return to work? _____

Is this patient temporarily disabled? □ Yes □ No If yes, what are the temporary restrictions/limitations? _____

_____

Certification: I certify that the above information is true and complete to the best of my knowledge. I know that any misrepresentation herein may lead to a rejection of the patient's application, and the Mississippi Attorney General's Office has the right to commence civil and/or criminal action for the misrepresentation of such information.

Signature of doctor: _____ **Date (mm/dd/yyyy)**_____

Name of doctor: _____ Phone: (_____)_____

Fax: (_____)_____**Tax ID or SSN:** _____

Address: _____

Email address: _____ **Patient #:**_____

Page 1: [1] Comment [Watermark1] **Comment**


ATTORNEY GENERAL
OFFICIAL
STATE OF MISSISSIPPI