MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM

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MEMBER'S DISABILITY APPEAL

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Member's Birth Date

Email Address

SECTION 2: APPEAL CERTIFICATION

You have the right to appeal the decision of the board-designated physician pursuant to La. R.S. 11:218(D). A written appeal must be filed within 30 days of notification of the certification of the board-designated physician's decision that you are not disabled.

In the application process, you will see another board-designated physician at your expense.

I wish to appeal the decision of the board-designated physician.

Member's Signature	Date