Rev. 01/2024

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM

7722 OFFICE PARK BOULEVARD, SUITE 200, BATON ROUGE, LA 70809-7601
Telephone: (225) 929-7411 • Toll Free: (800) 443-4248 • Fax: (225) 929-6542 www.lampers.org

MEMBER ENROLLMENT FORM

Municipality No.
To Be Completed By MPERS

SECTION I. EMPLOYEE INFORMATION

INSTRUCTIONS: This application is designed for multipurpose use and for data input. Type or print in black ink all entries.

SOCIAL SECURITY #:

Name (Last, First, Middle Initial)

Mailing Address

MARITAL STATUS (Check One)
☐ Married ☐ Widow(er)
☐ Single /Never married ☐ Divorced

City	State	Zip Code	Telephone No. Area Code ( )	Date of Birth	Mo	Day	Year	Sex ☐ M ☐ F

Personal Email

Original Date of Employment at Police Dept.	Mo	Day	Year	**MPERS Entry Date**	Mo	Day	Year

SECTION II. PREVIOUS ENROLLMENT

A. If you were at any time a member of this system, give name under which your membership was reported and dates employed.

From (Mo./Yr.)	To (Mo./Yr.)	STATUS: ☐ Refunded ☐ Transfer ☐ Inactive

B. Are you now or have you ever been a member of another Louisiana Public Retirement System? If Yes, which one(s) (list): ☐ Yes ☐ No

From (Mo./Yr.)	To (Mo./Yr.)

WHAT IS YOUR PRESENT STATUS IN OTHER LA PUBLIC SYSTEM? ➡
☐ Retired ☐ Refunded
☐ Active ☐ Inactive (Resigned, left contributions on deposit)

SECTION III. DESIGNATION OF PRINCIPAL BENEFICIARY(S)

I do hereby designate the following as my beneficiary: (include address if different from member)	Birthdate (Mo./Day/Yr.)	Social Security No.	Relationship
(Note: Principal beneficiary may be changed at any time prior to retirement.)			

I request the board of trustees of the Municipal Police Employees' Retirement System to pay, in the event of my death before retirement, the total amount of accumulated contributions standing to my credit in the retirement system to the designated beneficiary(s), otherwise, to my estate, unless benefits are payable to surviving spouse and/or children in accordance with Title 11 of Louisiana Revised Statutes.

Signature of Member	Date

Witness	Witness

SECTION IV. EMPLOYER CERTIFICATION (TO BE COMPLETED BY MUNICIPALITY PERSONNEL)

Employee's Position/Title (Include copy of job description)	Name of Town or City	Is employee covered by Social Security? ☐ Yes ☐ No Is position/title a Civil Service position? ☐ Yes ☐ No

At any time, currently or at a later date, is employee or will employee be **eligible** to receive state supplemental pay under current position/title? ☐ Yes ☐ No

If employee is not currently receiving state supplemental pay but will be **eligible** to receive state supplemental pay at a later date under current position/title, check yes.

This will certify that 100% of the services performed by the above-named employee are directly under the jurisdiction and/or supervision of the Chief of Police and his/her position is part of the police department and is included in the budget of said police department. Further, 100% of the salary earned by this employee is derived from the police department budget, except for state supplemental pay, and he/she is paid at least $375.00 per month by the municipality. This employee holds a full-time position.

Signature of Appointing Authority	Title of Appointing Authority	Date

MUNICIPAL POLICE EMPLOYEES' RETIREMENT SYSTEM
MEMBER ENROLLMENT FORM

TO: Board of Trustees
Municipal Police Employees' Retirement System
7722 Office Park Boulevard, Suite 200
Baton Rouge, LA 70809-7601

I hereby certify that as a new enrollee applying for membership in the Municipal Police Employees' Retirement System (MPERS), I have six (6) months from the date of employment to complete the enrollment process and become a fully active member of MPERS. The enrollment process begins with filling out the Member Enrollment Form and Medical History, having a physical examination and sending the forms to MPERS office.

I further understand that if I complete the process within the six (6) months period following employment, I will begin vesting for regular and disability benefits from the date of my employment. **If I do not complete the process within the six (6) months period, I will not begin vesting for disability benefits until the date I complete the enrollment process, although vesting for regular retirement will begin with the date of my employment.** If I am injured in the line of duty and apply for disability benefits, I will have the responsibility of proving that the condition was not preexisting.

I understand that the provisions of Louisiana Revised Statute 11:216 state that "Any disability claimed by a member of a state or statewide retirement system must have been incurred after commencement of service in the system with which the claim is filed. Disability claims shall not be honored in the case of preexisting conditions." **This in no way affects my membership in MPERS nor my eligibility to apply for disability benefits for condition(s) not preexisting.**

I certify that all information which I provided is accurate and complete. I understand that any misrepresentation or failure on my part, intentional or unintentional, to fully disclose any information may be grounds for disqualification from and denial of disability benefits from the Municipal Police Employees' Retirement System.

I agree to all examinations and tests deemed necessary and authorize any medical information obtained to be furnished to the Municipal Police Employees' Retirement System.

Typed or Printed Name _____

Signature_____ Date_____

Sworn to and subscribed before me this _____day of _____, 20____

_____
Notary Public

MEDICAL HISTORY (To Be Completed By Enrollee)

FAMILY HISTORY- Mark an X in the boxes to indicate illnesses of family members and death where appropriate. Use space provided to explain items checked.

	Cause of death				Age at death	Deceased	Other Illnesses	Tuberculosis	Stroke	Stomach trouble	Sickle Cell Anemia	Rheumatism/Arthritis	Nervous trouble	Muscular Dystrophy	Migraine headaches	Liver trouble	Kidney/bladder trouble	Heart trouble	Hearing trouble	Eye disease	Epilepsy	Diabetes	Cancer/tumor	Blood pressure problems	Anemia/bleed easily	Allergies/asthma
	Other Causes	Cancer	Heart trouble	Lung disease																						
Father																										
Mother																										
Blood relatives																										

YOUR HEALTH HISTORY - Mark an X in the space next to any of the following you now have or have ever had.
USE THE SPACE PROVIDED BELOW TO EXPLAIN ALL ITEMS CHECKED IN HEALTH AND MENTAL HISTORY. GIVE COMPLETE DETAILS INCLUDING ANY ILLNESSES, SURGERIES, ACCIDENTS, OR INJURIES.

____ Allergies/hay fever	____ Eye disease	____ Osteomyelitis
____ Amnesia	____ Eye injury	★ ____ Positive TB test
____ Anemia	____ Head injury (indicate type below)	____ Rheumatic Fever
____ Arthritis	____ Hearing trouble	____ Scarlet Fever
____ Asthma	____ Heart trouble	____ Sciatica
____ Back injury	____ Hematuria	____ Seizures
____ Back pain w/out injury	____ Hepatitis	____ Sickle Cell Anemia
____ Benign tumor	____ HIV (AIDS)	____ Skin sores
____ Bladder trouble	____ Infantile paralysis	____ Spinal meningitis
____ Bleed easily	____ Injury	____ Stomach trouble
____ Blood pressure problems	____ Kidney trouble	____ Stomach ulcer
____ Bronchitis	____ Liver trouble	____ Stroke
____ Cancer	____ Lung trouble	____ Surgery
____ Carpal tunnel syndrome	____ Malaria	★ ____ Thyroid trouble
____ Diabetes	____ Migraine headaches	____ TMJ trouble
____ Diphtheria	____ Multiple Sclerosis	★ ____ Tuberculosis
____ Emphysema	____ Muscular Dystrophy	____ Typhold Fever
____ Epilepsy	____ Muscular weakness	____ Venereal Disease
____ Encephalitis	____ Paralysis of a body part	____ (indicate type below)

★ Treatment Received?_____Yes _____No

Examining physician's initials_____ Applicant's Initials_____

MENTAL HEALTH - Have you ever been treated for: Mark an X in the space to indicate yes.

____ Depression	____ Nervousness	____ Schizophrenia
____ Insomnia	____ Paranoia	____ Stress

DATES	PHYSICIAN	REASON / CAUSE	TREATMENT RECEIVED	OUTCOME

FAMILY PHYSICIAN - Include name, address, phone number of physician(s) for the last 10 years.

_____

_____

HAVE YOU EVER BEEN: Mark an X in the space to indicate yes.
Rejected/discharged for medical reasons for:
____ Military service? ____ Insurance policy or rated?
____ Employment?

EXPLAIN ANY ITEMS CHECKED _____
_____
_____

HAVE YOU EVER MADE A WORK-RELATED CLAIM? ____ Yes ____ No
If yes, give date and explain fully_____
_____

HAVE YOU HAD OR ARE YOU EXPERIENCING ANY OF THE FOLLOWING? Mark an X in the appropriate space.

Now	Past		Now	Past	
		GENERAL			25. See double
		1. Gained weight recently?_____lbs.			26. See colored halos around lights
		2. Lost weight recently?_____lbs.			27. Temporary loss of sight
		3. On a special diet			28. Glaucoma
		4. Lost interest in eating.			29. Pain in eyes
		5. Seem to be hungry often			30. Difficulty in seeing
		6. More thirsty than usual			31. Trouble in distinguishing color
		7. Told too much sugar in system			32. Blindness (indicate which eye)_____
		8. Tendency to be too hot or too cold			33. Excessive tearing
		9. Have fever or chills			
		10. Feel exhausted or tired most of the time			EARS
		11. Difficulty falling or staying asleep			34. Others complain you don't hear them
					35. Feel you have difficulty hearing
		SKIN			36. Decreased hearing after accident or loud noise
		12. Psoriasis, acne, eczema or other skin trouble			
		13. Sores that won't heal			37. Earaches or ear infections
		14. X-ray treatment for skin or in neck area			38. Ears draining
		15. Skin rash due to:			39. Buzzing or ringing in ears
		soap, detergent			40. Motion sickness in car, plane or boat
		toiletries, cosmetics			41. Dizziness, lightheadedness or fainting
		poison ivy or oak			42. Loss of balance
		sunlight			43. Have hearing aid
		workplace			44. Deaf (indicate which ear)_____
		16. Boils, skin infections			
		17. Bruise easily			NOSE, MOUTH, THROAT
		18. Allergic reaction to insect bites			45. Sores or swelling of gums or jaws
		19. Changes in color of skin			46. Trouble with tasting
		20. Changes in nails or hair			47. Nose runs when you don't have a cold
					48. Throat sore when you don't have a cold
		EYES			49. Hoarseness
		21. Frequent headaches			50. Frequent flowing nosebleeds
		22. Eyesight getting worse			51. Swallowing difficult or painful
		23. Wear glasses			
		24. Wear contact lens			

Examining physician's initials _____ Applicant's initials _____

Now Past

CHEST

52. Tightness, crushing, squeezing in chest after eating
53. Date last chest x-ray_____ Results_____
54. Wheeze or gasp to breathe
55. Shortness of breath
56. Coughing spells
57. Cough phlegm (thick spit)
58. Cough up blood
59. Frequent chest colds
60. Sweating more frequetly or night sweats

HEART

61. Told you have hypertension
62. Told you have high blood pressure
63. Thumping, racing heart or irregular heartbeat
64. Told you have heart trouble
65. Pain or tightness in chest
66. Using more pillows to help breathe when lying down

STOMACH/BOWEL

67. Heartburn or indigestion
68. Nervous stomach
69. Belching, bloated after eating
70. Discomfort in pit of stomach
71. Feel like vomiting
72. Vomit blood or coffee ground-like material
73. Foods that don't agree with you
74. Diarrhea or constipation (indicate which)
75. Blood in stool
76. Black, tarry or very light color stools
77. Bleeding from rectum
78. Change in bowel habits

URINARY SYSTEM

79. Loss of bladder control when you cough or sneeze
80. Burning or pain when you urinate
81. Brown, black or bloody urine
82. Difficulty starting urine flow or dribbling
83. Very frequent urination or feeling of need to urinate
84. Bladder infections

MEN ONLY

85. Urine stream weak and slow
86. Prostate trouble
87. Burning or discharge from penis
88. Sore on penis
89. Genital warts
90. Lumps or swelling on testicles
91. Undescended testicle
92. Impotence

WOMEN ONLY

93. Trouble with menstrual periods
94. Use of birth control pills
95. Lumps in breast or armpits
96. Bleeding, pain, discharge from nipple (indicate which)_____

Now Past

97. Genital warts
98. Date of last PAP smear_____
99. Date of last menstrual period_____
100. Number of pregnancies_____
101. _____Full term
_____Miscarriage
_____Other
102. Date last mammogram_____ Results_____

NERVOUS SYSTEM

103. Slurred speech or loss of speech
104. Weakness on one side of body
105. Tendency to shake or tremble
106. Dizziness or fainting
107. Numbness or tingling in any body part
108. Difficulty in walking

EXTREMITIES

109. Stiff, swollen or painful muscles or joints
110. Trouble stopping cuts from bleeding
111. Varicose veins
112. Vein or artery disease
113. Pains in back
114. Pains in shoulder or neck
115. Lumps, swelling in neck or glands
116. Any back problem
117. Ever worn a back brace
118. Ever worn a knee brace
119. Inflamed veins or blood clots in arms or legs
120. Numbness or tingling in cold weather
121. Cramps in legs
122. Swollen feet or ankles
123. Painful feet
124. Burning of soles of feet

TOBACCO

125. Use tobacco in any form
126. If yes, specify form
_____Cigarettes
_____Cigars
_____Pipe
_____Chew tobacco
_____Dip snuff
127. Amount daily_____
128. How many years_____
129. If you no longer use tobacco, month and year you stopped_____

DRUGS

130. Illegal use of controlled drugs
131. Treated for durg problem
If yes, when and where_____
_____

ALCOHOLIC BEVERAGES

132. Use alcoholic beverage of any kind
133. Frequency_____
134. How much - 1 drink = 1 jigger alcohol, 1 beer or 1 glass wine
(Mark an X in appropriate box)

Less than 1	1-2	2-4	5-6	More than 6
☐	☐	☐	☐	☐

135. Been told you have a drinking problem
136. Do you have a drinking problem
137. Ever treated for alcohol problem
If yes, when and where_____

Examining physician's initials_____

Applicant's initials_____

MEDICINES - Mark an X in the space to indicate medicines you have ever taken or are now taking.

Now	Past		Now	Past		Now	Past	
		Antacids			Dilantin/anticonvulsants			Nose drops
		Antibiotics			Diuretics/water pills			Sedatives
		Birth control pills			Heart medicine			Stimulants
		Blood thinners			Blood pressure medicine			Tranquilizers
		Codeine			Insulin			_____
		Cortisone-type drugs ★			Laxatives			_____
		Diet pills			Muscle relaxants			_____

★ Specify reason for use of cortisone-type drug (infection, injury, arthritis) _____

_____

List dosage and frequency of medicines you are currently taking_____

_____

_____

List all medicines you are allergic to _____

_____

PART B – PHYSICAL EXAMINATION

Applicant's Name_____

PHYSICAL EXAMINATION - To be completed by physician performing examination. Indicate every item which is not within normal limits by placing an X in space provided.

1. GENERAL
   - Posture
   - Gait

2. SKIN
   - Color
   - Texture
   - Sweaty
   - Scars
   - Eruptions
   - Ulcers
   - Petechiae

3. HEAD
   - Shape
   - Hair
   - Masses
   - Tenderness
   - Bruit
   - Sinus

4. EARS
   - External
   - Pinna
   - Canal
   - Drum

5. EYES
   - Muscles
   - Lids
   - Conjunctivae
   - Cornea
   - Pupils
   - Fundi
   - Macula
   - Disk
   - Arteries
   - Veins
   - Exudate

6. MOUTH/THROAT
   - Lips
   - Breath
   - Mucosa
   - Dentures
   - Teeth
   - Tongue
   - Gingiva
   - Floor
   - Palate
   - Pharynx
   - Tonsilis
   - Larynx

7. NOSE
   - Septum
   - Obstruction
   - Mucosa
   - Sinus

8. NECK
   - Thyroid
   - Trachea
   - Veins
   - Masses
   - Bruit
   - Carotid
   - Spine
   - Range of Motion

9. LUNGS
   - Expansion
   - Breath sounds
   - Rales
   - Wheezes
   - Rubs
   - Rhonchi
   - Respiratory rate

10. HEART
    - Rate
    - Rhythm
    - Thrill
    - Masses
    - Rubs
    - Murmurs
    - Gallops

11. BREASTS
    - Nodes
    - Discharge
    - Nipple
    - Areola
    - Symmetry
    - Consistency
    - Scars
    - Masses

12. ABDOMEN
    - Contour
    - Tenderness
    - Masses
    - Hernia
    - Liver size_____cm
    - Liver edge
      - Smooth
      - Irregular
      - Nodular
    - Spleen size
    - CVA tenderness
    - Rebound

13. FEMALE GENITO-URINARY
    - Labia
    - Clitoris
    - Bartholin's gland
    - Urethra
    - Perineum
    - Introitus
    - Vagina
    - Cervix
    - Uterus
    - Adnexa
    - Cul-de-sac
    - Discharge

14. MALE GENITO-URINARY
    - Penis
    - Meatus
    - Epididymis
    - Varicocele
    - Testicles
    - Discharge
    - Hernia
    - Prostate
    - Scars

15. RECTAL
    - Anus
    - Sphincter
    - Hemorrhoids
    - Mucosa
    - Masses
    - Pilonidal
    - Fissure

16. NEUROLOGIC
    - Grasp
    - Plantar
    - Biceps
    - Triceps
    - Knee
    - Ankle
    - Romberg
    - Babinski
    - Coordination
    - Tremor
    - Vibratory
    - Cranial Nerves
    - Sensory

17. MUSCULOSKELETAL
    - Shoulder
    - Arm
    - Elbow
    - Radial pulse
    - Wrist
    - Hand
    - Fingers
    - Fingernails
    - Spine
      - Kyphosis
      - Lordosis
      - Scoliosis
    - Hip
    - Leg
    - Knee
    - Ankle
    - Foot
    - Pedal pulse
    - Toes
    - Toenails
    - Joints

18. EXTREMETIES
    - Clubbing
    - Cyanosis
    - Edema
    - Veins
    - Stasis
    - Ulceration
    - Hair distribution

19. EMOTIONAL
    - Speech
    - Affect
    - Orientation
    - Memory

Examining physician's initials_____ Applicant's initials_____

Height _____ Weight _____ Temperature _____

Blood Pressure _____ If 140/90 or above, recheck in 5 minutes _____

Pulse before exercise _____ After jogging in place 1 minute _____ After 2 minutes rest _____

Vision uncorrected _____ Corrected _____

Hearing (20 feet) _____ Rinne _____ Weber _____

LABORATORY INFORMATION - Attach Reports

Metabolic Panel

CBC

Routine urinalysis

Urine drug screen - To include amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, opiates, phencyclidine

Indicate Results

VDRL _____ TB skin test _____

AIDS (HIV) _____

Remarks on laboratory results _____

_____

_____

List every item which needs explanation, including items from family history, applicant's history, physical examination and laboratory results.

PROBLEM	PLAN

From your examination of _____, do you consider applicant to have any pre-existing conditions that would disqualify the applicant from a disability retirement with the retirement system? _____

If yes, please list pre-existing conditions _____

_____

_____

This examination and resulting information truly depicts the condition of the applicant on the _____day of _____ , _____ .

_____ _____

Examining physician's name (Type or Print) Examining physician's signature

_____ _____

Address Telephone No.