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

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

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. 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: _____

_____

_____

_____

APPLICANT NAME _____ **SSN** _____

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)
_____	_____	_____

APPLICANT NAME _____ **SSN** _____

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 #:** _____