

**U.S. DEPARTMENT OF JUSTICE
OFFICE OF JUSTICE PROGRAMS
BUREAU OF JUSTICE ASSISTANCE
PUBLIC SAFETY OFFICERS' BENEFITS PROGRAM
WASHINGTON, D.C. 20531
REPORT OF PUBLIC SAFETY OFFICERS'
PERMANENT AND TOTAL DISABILITY**

FOR BJA USE ONLY

PDC _____

CASE # _____

DATE RECEIVED _____

This information is being requested pursuant to the Omnibus Crime Control and Safe Streets Act of 1968, as amended (42 U.S.C. 3796) and the disclosure is voluntary. This form will be used by the Department of Justice to determine eligibility of a permanently and totally disabled officer for the payment of benefits, and the information may be disclosed to Federal, State, and local agencies to verify eligibility for benefits. Disclosure of an individual's Social Security number is voluntary. Failure to supply all of the requested information may result in a delay in processing this form and the receipt of benefits. **PLEASE PRINT PLAINLY OR TYPE.**

1. NAME, ADDRESS, AND TELEPHONE NUMBER OF DISABLED OFFICER

2. SOCIAL SECURITY NO.

3. DATE OF BIRTH

4. DATE OF INJURY

5. STATEMENT ON OTHER CLAIMS FILED WITH THE UNITED STATES GOVERNMENT AND/OR THE DISTRICT OF COLUMBIA: Claim has been filed for benefits under (please circle):

(1) Federal Employees Compensation Act, Section 8191 Title 5, U.S. Code? YES NO

(2) D.C. Retirement and Disability Act of September 1, 1916, Sec. 4-622? YES NO

6. NAME AND MAILING ADDRESS OF PUBLIC SAFETY AGENCY, ORGANIZATION OR UNIT IN WHOSE SERVICE THE INJURY OCCURRED

7. NAME OF DISABLED OFFICER'S SUPERIOR OFFICER

8. TELEPHONE NO.

9. PLEASE CIRCLE OFFICER'S EMPLOYMENT STATUS WHEN INJURY OCCURRED

FULL-TIME

PART-TIME

VOLUNTEER

OTHER (Specify) _____

10. PLEASE CIRCLE AND ATTACH ALL APPLICABLE REPORTS RELATING TO THE DIRECT CAUSE OF THE PERMANENT AND TOTAL DISABILITY. PROVIDE A CERTIFIED COPY OF ORIGINAL REPORTS.

DETAILED STATEMENT OF CIRCUMSTANCES

MEDICAL/HOSPITAL RECORDS

INVESTIGATION

TOXICOLOGY ANALYSIS

OTHER

11. AT THE TIME OF THE INJURY THAT CAUSED THE PERMANENT AND TOTAL DISABILITY WAS THE OFFICER
WORKING A REGULAR SHIFT? AN OVERTIME SHIFT ? OR OFF DUTY? PLEASE CHECK ONE. IF OFF DUTY, PLEASE ATTACH THE RULES,
REGULATION OR LAW AUTHORIZING OR OBLIGATING THE OFFICER TO ACT IN THE LINE OF DUTY OUTSIDE OF SCHEDULED DUTY HOURS.

<u>AS A</u>	<u>IN THE SERVICE OF</u>
<u> </u> POLICE OFFICER	<u> </u> STATE GOVERNMENT
<u> </u> CORRECTIONS OFFICER	<u> </u> LOCAL UNIT OF GOVERNMENT
<u> </u> PROBATION OFFICER	<u> </u> FEDERAL GOVERNMENT
<u> </u> PAROLE OFFICER	<u> </u> LEGALLY ORGANIZED VOLUNTEER FIRE, AMBULANCE OR RESCUE SQUAD DEPARTMENT ORGANIZED, CHARTERED OR FORMED BY A PUBLIC SAFETY AGENCY TO ACT ON ITS BEHALF IN PROVIDING FIRE OR RESCUE SERVICE TO THE PUBLIC
<u> </u> FIREFIGHTER	
<u> </u> AMBULANCE AND RESCUE SQUAD MEMBER	<u> </u> OTHER (Specify) _____
<u> </u> OTHER (Specify)	

IN THE SERVICE OF

STATE GOVERNMENT

LOCAL UNIT OF GOVERNMENT

FEDERAL GOVERNMENT

LEGALLY ORGANIZED VOLUNTEER FIRE, AMBULANCE OR RESCUE SQUAD
DEPARTMENT ORGANIZED, CHARTERED OR FORMED BY A PUBLIC
SAFETY AGENCY TO ACT ON ITS BEHALF IN PROVIDING FIRE OR RESCUE
SERVICE TO THE PUBLIC

SERVICE TO THE PUBLIC

OTHER (Specify) _____

12. WAS THE OFFICER'S INJURY THE RESULT OF:	YES	NO	UNKNOWN
GROSS NEGLIGENCE?			
INTENTIONAL MISCONDUCT?			
INTENT TO BRING ABOUT OWN INJURY?			
VOLUNTARY INTOXICATION?			

VOLUNTARY INTOXICATION?

13. IF KNOWN, GIVE NAME AND ADDRESS OF WITNESS(ES) TO THE OFFICER'S INJURY IF NOT PROVIDED IN INVESTIGATIVE REPORTS.

CERTIFICATIONS: A false answer to any question in this Statement may be grounds for non-payment of benefits and may be punishable by fine or imprisonment (U.S.Code, Title 18, Sec. 1001). All the information will be considered in reviewing the claim and is subject to investigation.

14. EMPLOYING ORGANIZATION - To the best of our knowledge and belief, the above information is factual and complete.

SIGNATURE OF EMPLOYING AGENCY HEAD

DATE _____

15. Signature of Disabled Officer or Authorized Representative (If representative, provide officer's affidavit granting power of attorney)

Signature	Date
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Date

Under the Paperwork Reduction Act, a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. The estimated average time to complete and file this application is 120 minutes per application. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Public Safety Officers' Benefits Program, 810 7th Street, N.W., Washington, D.C. 20531.