

**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

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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

