Documentation in Support of Disability Retirement Application

This package contains the forms applicants for disability retirement from civilian Federal service need to complete. You should have received with this package a pamphlet entitled: *Information About Disability Retirement*. If you did not receive the information pamphlet, ask your agency to give you one. This package contains the following forms: Standard Form 3112A, *Applicant's Statement of Disability*, Standard Form 3112B, *Supervisor's Statement*, Standard Form 3112C, *Licensed Healthcare Practitioner's Statement*, Standard Form 3112D, *Agency Certification of Reassignment and Accommodation Efforts*, and Standard Form 3112E, *Disability Retirement Application Checklist*.

You should keep one copy each of the completed forms for your own records. Your agency will send the originals of each form to the Office of Personnel Management (OPM). You must obtain the evidence that will enable OPM to decide that your disease or injury is so severe that you can no longer perform useful or efficient service, or that you have a medical condition that requires restrictions from critical duties of your job.

You can help speed the processing of your application. Make sure all the information requested on the forms is provided. Put a copy of your position description with the forms you give your licensed healthcare practitioner(s). See that the information you submit contains diagnosis, prognosis, and a treatment plan dated no more than 60 days before the date your application is filed. Although we accept all medical evidence about your disease or injury, current evidence provides the best support of your application.

If you are applying for disability retirement under the Federal Employees Retirement System (FERS) or the Civil Service Retirement System (CSRS) with offset service, you must document that you have applied for Social Security disability benefits. The application receipt or award notice that you receive when you apply for Social Security benefits should be attached to your application. Your application cannot be completely processed without this information. ***Important:*** If Social Security awards you benefits, your payments from OPM must be reduced starting on the date the Social Security award started. Since this may result in an overpayment of OPM benefits, you should ***not*** spend any of the money from Social Security until your annuity from OPM has been reduced and OPM has billed you for any overpayment. OPM is required by law to collect any annuity overpayment. If any or all of the overpayment cannot be repaid, OPM may have to start debt collection procedures

If you are not separated from Federal Service, return all the completed forms and associated documents to your agency's personnel office. Your personnel office will assemble your disability retirement application package and send it to OPM. Please follow up with your agency to be sure they send your application to OPM.

If you have been separated from Federal service for more than 31 days, you need to give each form to the appropriate individual and ask that the completed forms be ***returned to you*** so you can assemble your disability retirement application package yourself and send it to OPM at:

U.S. Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045

OPM must receive your application not more than one year after the date you separated from your position. If you are unable to get all the information requested, do not delay submitting your Standard Form 3112A to OPM. See the accompanying pamphlet for an explanation of exceptions.

(continued on reverse)

Applicant's Statement of Disability

In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees Retirement System

CSRS Civil Service Retirement System

FERS Federal Employees Retirement System

A copy of this completed form must accompany the Supervisor's Statement you give your supervisor(s).

OMB Approval 3206-0228

1. Name *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number

4. Fully describe your disease(s) or injury(ies.) We consider only the diseases and/or injuries you discuss in this application.

5. Describe how your disease(s) or injury(ies) interferes with performance of your duties, your attendance, or your conduct.

6. Describe any other restrictions of your activities imposed by your disease or injury.

7a. What accommodations have you requested from your agency?

7b. Has your agency been able to grant your request? *(Attach an explanation or any documentation that you have regarding accommodation.)*

☐ Yes ☐ No

7c. What is your current status with your agency?

☐ In pay status; and working without accommodation.

☐ In pay status; and working with accommodation.

☐ In leave without pay status.*

☐ Separated from service.*

**If you are currently in a leave without pay status or separated from service, what job(s), if any, have you performed since going into this status? Please explain the physical and/or mental requirements for this (those) job(s).*

8. Give the approximate date you became disabled for your position *(mm/yyyy)*.	9. Have you been hospitalized for your disease or injury as described in item 4? ☐ Yes ☐ No	10. Give date of most recent hospitalization. From *(mm/yyyy)* / To *(mm/yyyy)*

11. ***Notice for FERS and CSRS Offset Applicants ONLY***
Application for disability retirement under FERS or CSRS Offset requires an application for Social Security Disability Benefits. Final processing at OPM cannot be completed without a copy of your Social Security Disability application, receipt, or award notice.

11a. Have you applied for disability benefits from the Social Security Administration?	11b. Is this application receipt or award notice attached?
☐ Yes ☐ No	☐ Yes ☐ No

12. List the licensed healthcare practitioner(s) name(s), address(es), and dates of treatment from whom you plan to request Licensed Healthcare Practitioner's Statement (SF 3112C). Attach an additional sheet if you wish to list more licensed healthcare practitioners.

Name	Address	Date of Treatments

13. **Applicant's Consent and Certification**

I certify that all statements made above are true to the best of my knowledge and belief. I give my permission for the release of information about my service and medical condition(s) (i.e., disease or injury) to authorized agency and OPM officials. I have read and understand all of the information provided in the instructions to this application.

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

Signature *(do not print)*

Date *(mm/dd/yyyy)*

Daytime telephone number

( )

E-mail address

Privacy Act Statement

Pursuant to 5 U.S.C.§ 552a(e)(3), this Privacy Act Statement serves to inform you of why OPM is requesting the information on this form. **Authority:** OPM is authorized to collect the information requested on this form by 5 U.S.C. §§ 8342 and 8451, which provide that OPM will determine whether employees and former employees who apply for disability retirement are eligible for that benefit. OPM is authorized to collect your Social Security number by Executive Order 9397 (November 22, 1943), as amended by Executive Order 13478 (November 18, 2008). **Purpose:** The data you furnish will be used to determine the allowance or disallowance of the disability retirement application. **Routine Uses:** The information requested on this form may be shared externally as a "routine use" to other Federal agencies and third-parties when it is necessary to process your application. For example, OPM may share your information with other Federal, state, or local agencies and organizations in order to determine benefits under their programs, to obtain information necessary for determining your eligibility for refund, or to report income for tax purposes. OPM may also share your information with law enforcement agencies if it becomes aware of a violation or potential violation of civil or criminal law. A complete list of the routine uses can be found in the *OPM/ CENTRAL 1 Civil Service Retirement and Insurance Records* system of records notice, available at *www.opm.gov/privacy*. **Consequences of Failure to Provide Information:** Providing this information to OPM is voluntary. However, if this information were not provided, OPM would be unable to determine whether the applicant meets the legal requirements for disability retirement.

Public Burden Statement

The public reporting burden to complete this information collection is estimated at 30 minutes per response, including for reviewing instructions, searching data sources, gathering and maintaining the data needed, and completing and reviewing the collected information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Personnel Management, RS Publications Team at RSPublicationsTeam@OPM.gov. Current information regarding this collection of information – including all background materials -- can be found at https:/www.reginfo.gov/public/do/PRAMain by using the search function to enter either the title of the collection or OMB Control Number 3206-0228.

Supervisor's Statement

In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees Retirement System

This form should be completed by the immediate supervisor or someone who is in a position to observe the applicant on a regular basis.

OMB Approval 3206-0228

Instructions

All sections of this form must be completed properly. Failure to do so will delay the processing of the disability application at OPM.

The employee identified in Section A has indicated that he or she intends to apply for disability retirement. The applicant's signature on the *"Applicant's Statement"* authorizes his or her immediate supervisor *(or a supervisor who was or is in a position to observe the applicant on a regular basis)* to provide the information and documentation requested. The immediate supervisor is asked to provide information about the applicant's job, performance, attendance, and conduct.

If you need more space in any section, attach a separate sheet and indicate that an attachment is provided.

The following definitions apply to the terms used in the *Supervisor's Statement*.

- *"Less than fully successful performance"* means performance of an employee which fails to meet established performance standards in one or more critical elements of the employee's position or the equivalent level for a position not under 5 CFR part 430.
- *"Critical element"* means a component of an employee's job that is of sufficient importance that performing below the minimum standard established by management requires remedial action, such as denial of within-grade increase, and may be the basis for reducing the grade level or removing the employee.
- *"Unacceptable attendance"* means absence from work which is too frequent, unpredictable, or lengthy to allow the job to be done.
- *"Unsatisfactory conduct"* means conduct for which an employee may be removed or disciplined for cause under adverse action procedures. (For example, discourteous conduct to the public, behavior which poses a threat to the life, health, safety, or well-being of co-workers, subordinates, or the public.)
- *"Accommodation"* means an adjustment made to a job and/or work environment that enables a qualified handicapped person to perform the duties of that position. Reasonable accommodation may include modifying the work-site, adjusting the work schedule, restructuring the job, acquiring or modifying equipment or devices, providing interpreters, readers or personal assistants, and reassigning or retraining employees.
- *"5 CFR 531.409(d)"* is the regulation that provides for a waiver of the requirements for determination of an employee's level of competence in certain cases when the employee was in duty status for less than 60 days during the 52 calendar weeks before a within-grade increase would be due.

After completing and certifying this form and attaching the appropriate documentation, you should return the original to the employee or to your personnel office according to instructions and practices in your agency. In either case, ***a copy must be given to the employee***. Please ***do not*** send the form directly to OPM unless OPM specifically requested you to do so.

If necessary, you may be contacted by OPM for additional information or clarification.

Section A - Applicant Identification

1. Name *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number

Section B - Information About Employee's Performance

(See instructions above)

1. Title of position of record. *(Attach a copy of position description and current performance standards. If available, attach a copy of the latest performance appraisal.)*	2. Date of entry into position *(mm/dd/yyyy)*

3. Is performance less than fully successful in any critical element of position?

☐ Yes, complete items 4 - 6 of this section. ☐ No, go to Section C.

4. Show the approximate date *(mm/yyyy)* that unacceptable performance or the inability to do the job began.	5. After the date in item 4, has the employee received a within-grade step increase or an award based on performance of a critical element.?	5a. Was within-grade increase granted under 5 CFR 531.40(d)? *(see instructions)*
	☐ Yes → Period the increase or award covered. From *(mm/yyyy)* To *(mm/yyyy)* ☐ No	☐ Yes ☐ No

6. Identify any critical element(s) of the position which employee does not perform successfully or at all. Explain the deficiencies you observed. Attach supporting documentation such as notice to the employee that performance is less than fully successful or licensed healthcare practitioner's recommendation regarding medical restrictions.

Section C - Information About Employee's Attendance

1. Has the employee stopped coming to work?

☐ No ☐ Yes, how long is absence expected to continue *(if known)*?

2. Is the employee's attendance unacceptable for continuing in current position?

☐ No ☐ Yes, attendance stopped or became unacceptable on *(mm/yyyy)*:

3. Explain the impact of employee's absence on your work operations.

4. How many hours of leave has employee used for apparent medical reasons since date in item C2? *(Attach copies of medical information on which you based your decision to approve leave, leave records, records of contact with or notices to employee. Include as much information as possible about specific reasons for leave use.)*

	Annual	*Sick*	*LWOP*
Enter Leave Hours Used			

Section D - Information About Employee's Conduct

1. Is employee's conduct unsatisfactory?

☐ No, go to Section E. ☐ Yes, conduct became unsatisfactory on *(mm/yyyy)*:

2. Describe how conduct is unsatisfactory *(attach supporting documentation, such as notice to employee of proposed adverse action).*

Section E - Accommodation and Reassignment

(Consult with agency Coordinator for Employment of the Handicapped)

1. What efforts have been made to accommodate the employee in current position?

2. Has the employee been reassigned to a new permanent position? *(If yes, to what position and when?)*

☐ No ☐ Yes, to _____ on *(mm/yyyy)*:

3. Has the employee been reassigned to *"light duty"* or a temporary position?

☐ No, go to Section F. ☐ Yes

4. Describe the reason for temporary nature of assignment and length of time the employee is expected to occupy the position.

Section F - Supervisor's Certification

1. How long have you supervised the employee?

2. I certify that all statements made on this Supervisor's Statement are true to the best of my knowledge and belief.

2a. Supervisor's signature

2b. Date *(mm/dd/yyyy)*

2c. Supervisor's name *(type or print legibly)*

2d. Supervisor's office mailing address

2e. Supervisor's daytime telephone number *(including area code)*

2f. E-mail address

Licensed Healthcare Practitioner's Statement

In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees Retirement System

CSRS Civil Service Retirement System

FERS Federal Employees Retirement System

Applicant must attach a copy of the most current position description

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Section A - Identifying Information and Consent

(to be completed by the applicant)

1. Name *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number

If you are currently employed by your agency or separated for less than 30 days, enter exact name and address including the name of the person or office in your employing agency where this information should be mailed. ➔	4. Enter the exact name and address *(including ZIP Code)*.
If you have been separated from your employing agency for 31 days or more provide your current home address. ➔	
Applicant's Consent to Release Medical Information	**5. I authorize the release to the Office of Personnel Management and my employing agency of any and all information or records connected with my disability retirement application.**

Signature *(do not print)*	Date *(mm/dd/yyyy)*

Privacy Act Statement

Pursuant to 5 U.S.C. § 552a(e)(3), this Privacy Act Statement serves to inform you of why OPM is requesting the information on this form. **Authority:** OPM is authorized to collect the information requested on this form by 5 U.S.C. §§ 8342 and 8451, which provide that OPM will determine whether employees and former employees who apply for disability retirement are eligible for that benefit. OPM is authorized to collect your Social Security number by Executive Order 9397 (November 22, 1943), as amended by Executive Order 13478 (November 18, 2008). **Purpose:** The data you furnish will be used to determine the allowance or disallowance of the disability retirement application. **Routine Uses:** The information requested on this form may be shared externally as a "routine use" to other Federal agencies and third-parties when it is necessary to process your application. For example, OPM may share your information with other Federal, state, or local agencies and organizations in order to determine benefits under their programs, to obtain information necessary for determining your eligibility for refund, or to report income for tax purposes. OPM may also share your information with law enforcement agencies if it becomes aware of a violation or potential violation of civil or criminal law. A complete list of the routine uses can be found in the *OPM/CENTRAL 1 Civil Service Retirement and Insurance Records* system of records notice, available at *www.opm.gov/privacy*. **Consequences of Failure to Provide Information:** Providing this information to OPM is voluntary. However, if this information were not provided, OPM would be unable to determine whether the applicant meets the legal requirements for disability retirement.

Public Burden Statement

The public reporting burden to complete this information collection is estimated at 60 minutes per response, including for reviewing instructions, searching data sources, gathering and maintaining the data needed, and completing and reviewing the collected information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Personnel Management, RS Publications Team at RSPublicationsTeam@OPM.gov. Current information regarding this collection of information – including all background materials -- can be found at https:/www.reginfo.gov/public/do/PRAMain by using the search function to enter either the title of the collection or OMB Control Number 3206-0228.

Section B - Medical Documentation *(to be completed by licensed healthcare practitioner)*

Instructions

The individual identified above is requesting medical documentation that will be evaluated, along with non-medical documentation, in connection with his or her application for disability retirement from Federal Government service. Please include all objective findings and reports concerning the individual's condition. This documentation may also be used in determining his or her eligibility for reassignment to a position that he or she is medically able to perform. A copy of his or her position description is attached for your information.

- Please provide the medical documentation requested under *"Medical Documentation Requirements"* on your letterhead stationery. It is important that you respond to every item listed. Enter the item number of the information requested and provide your response. If an item is not applicable to the applicant's medical condition, enter *"Not Applicable."* Include in your statement the identifying information in Section A, items 1 through 3, above. Your failure to provide complete information will delay the processing of your patient's disability retirement application.

- Enclose your report and any attachments in a sealed envelope marked *"Medical Disability - Privileged - Private."* Please make sure copies of all medical reports referenced in your statement are included. Send the envelope to the address shown in item 4 above. You may, if you wish, give it directly to the applicant for delivery to the appropriate office.

- Please complete this statement within 2 weeks. Be sure to sign the report. Include your address and telephone number.

- The applicant is responsible for any costs incurred in connection with providing this documentation.

(continued on reverse)

Medical Documentation Requirements

You must provide the following:

1. A comprehensive history of this patient's medical condition(s). This must include ***detailed information*** regarding the symptoms and history, past and current physical findings, results of laboratory studies and therapy of this condition(s). The medical documentation must contain specific information to show why this patient is not able to perform his or her duties. The medical documentation should not be conclusory. Provide a discussion of patient compliance with therapy, response to therapy, and plans for future therapy. Also, provide copies of pertinent hospitalization summaries and operative reports.
2. Copies of reports of all applicable diagnostic laboratory tests *(e.g., hematologic, chemistry, electrophysiologic, radiologic, nuclear medicine).* In the case of psychiatric disorders, provide the results of mental status examinations, personality tests, test of cognitive function, educational evaluation, neuropsychiatric tests, etc.
3. Diagnosis of patient's condition(s). Preferably each diagnosis should be found in the current publication, *"International Classification of Disease."* In the case of psychiatric disorders, diagnostic titles and codes from the DSM-5(R) should be used.
4. An assessment of the degree to which the medical condition(s) has or has not become static and ***an estimate of the expected date of full or partial recovery or remission***.
5. If restrictions have been placed on this patient's activities, please state what they are, why they have been imposed, and how long you expect these to be in effect.

General Information

Disability retirement determinations are made in accordance with Federal retirement regulations. A person is entitled to disability retirement benefits only when the information submitted with the application shows that an employee is unable to perform useful and efficient service because of disease or injury ***(1)*** in the employee's current position or ***(2)*** within a vacant position, in the same agency and commuting area at the same grade or pay level and tenure, for which the employee is qualified for reassignment. Useful and efficient service means fully successful performance of the critical or essential elements of the position (or the ability to perform at that level) and satisfactory conduct and attendance.

Agency Certification of Reassignment and Accommodation Efforts

In Connection With Disability Retirement Under the Civil Service Retirement System or the Federal Employees Retirement System

CSRS Civil Service Retirement System

FERS Federal Employees Retirement System

OMB Approval 3206-0228

Instructions

The Coordinator for Employment of the Handicapped should review the *Applicant's Statement*, the *Supervisor's Statement*, the *Licensed Healthcare Practitioner's Statement*, and any other relevant documentation on file to determine if reasonable accommodation will enable the employee to perform fully successful service in his or her current position or whether a vacant position is available in the agency, at the same grade or pay level in the same commuting area, for which the employee is qualified for reassignment. Take special note of the *Supervisor's Statement* and resolve any discrepancies between the information on that form and this form. Telephone numbers for the applicant, the supervisor, and the licensed healthcare practitioner may be found on their respective statements should it be necessary to contact them for further information.

If the employee is eligible to retire voluntarily, the employee should be advised of that fact. In general there is no difference in the payment to a disabled annuitant and an optionally retired annuitant, nor are there Federal tax advantages for a disability retiree.

All items must be completed. In items 4, 5, and 6, if you check a box that requires additional explanation, please provide the explanation and/or attachment. This will enable us to process the application without delay.

Accommodation *(item 4)* - Guidance for determining reasonable accommodations may be found in 29 CFR 1614.203(c). The documentation supporting your response to item 4 must include an assessment of the functional and environmental factors related to the employee's inability to perform at the fully successful level, unless there are no medical restrictions.

Reassignment *(item 5)* - Guidance related to reassignment of an applicant for disability retirement is published in OPM's *"CSRS and FERS Handbook for Personnel and Payroll Offices."*

After completing and certifying this form, please attach the appropriate documentation and return the original to the employee or to your personnel office according to instructions and practices in your agency. In either case, ***a copy must be given to the employee***. Please ***do not*** send the form directly to OPM unless OPM specifically requested you to do so in this case.

Your agency's obligation to continue to try to accommodate or reassign the employee does not cease with the filing of this certification. Your efforts should continue. If the accommodation or reassignment situation changes after the original filing of the certification, you must notify OPM of the changes.

OPM may contact you for additional information or clarification.

To be completed by Selective Placement Program Coordinator or other authorized agency official.

See instructions at the top of this page

1. Name of applicant *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number

4. Has reasonable effort for accommodation been made? *(You must check one statement below.)*

☐ **No, the medical evidence presented to the agency shows that accommodation is not possible due to severity of medical condition and the physical requirements of the position.** *(Attach copies of all medical evidence supporting the statement and explain why conditions prohibit accommodation. Also, provide a detailed statement of the physical requirements of the position.)* Employees should be counseled concerning the following: The fact that your agency has determined accommodation to be unavailable due to status of a medical condition or due to restriction imposed by a licensed healthcare practitioner does not guarantee that OPM will reach the same decisions about the approval of a disability retirement application.

☐ **No,** the employee's condition does not appear to require accommodation. Medical information presented to agency does not document a disabling medical condition.

☐ **Yes,** describe below accommodation efforts made, attach supporting documentation and provide narrative analysis of any unsuccessful accommodation efforts.

(continued on reverse)

5. Results of agency reassignment efforts *(You must check one statement below.)*

☐ Reassignment is not necessary because employee's performance is fully successful and there are no medical restrictions which keep the employee from performing critical duties or from attending work altogether.

☐ Reassignment is not possible. There are no vacant positions at this agency, at the same grade or pay level and tenure within the same commuting area, for which the employee meets minimum qualifications standards.

☐ The employee declined reassignment to a vacant position(s) in this agency at the same grade or pay level and tenure, within the same commuting area, for which the employee meets minimum qualifications. *(Attach a copy of any reassignment offers.)*

☐ The agency did not reassign the employee to the vacant position(s) in this agency, at the same grade or pay level and tenure within the same commuting area, for which the employee meets minimum qualifications. The position(s) identified and reason(s) for non-assignment are shown below.

Position Title	***Reason for Non-Reassignment for Non-Selection****

** If the employee's medical condition precludes reassignment to the position, attach documentation. If the reason for non-selection is intended removal, attach a copy of the removal notice to the employee.*

6. Is the employee currently occupying a temporary position?

☐ **No,** the employee is occupying a permanent position.

☐ **Not applicable,** the employee is no longer an employee of the agency.

☐ **Yes,** state below the nature of these duties, the reason for the temporary status, and length of time the agency expects the employee to occupy this position.

Certification by Selective Placement Program Coordinator or other authorized agency official.

7. **I certify that this statement is true to the best of my knowledge and belief.**

7a. Signature of responsible agency official	7b. Title of responsible agency official	7c. Date *(mm/dd/yyyy)*
7d. Name of responsible agency official *(type or print legibly)*	7e. Telephone number *(including area code)*	
7f. E-mail address		

Disability Retirement Application Checklisht

For Disability Retirement under the Civil Service Retirement System
and the Federal Employees Retirement System
(to be completed by employing agency)

CSRS Civil Service Retirement System

FERS Federal Employees Retirement System

OMB Approval 3206-0228

1. Name of applicant *(last, first, middle)*	2. Date of birth *(mm/dd/yyyy)*	3. Social security number
4. Do available records show that the employee has at least 5 years of civilian service under the Civil Service Retirement System or at least 18 months under the Federal Employees Retirement System? ☐ Yes ☐ No		
5. Will employee remain in duty status? ☐ Yes ☐ No	5a. Show the date pay stopped or will stop. *(mm/dd/yyyy)*	
6. Has employee ever received or made application for compensation from the Department of Veterans' Affairs? ☐ Yes ☐ No	6a. Claim number	6b. Period compensation was received From *(mm/yyyy)* To *(mm/yyyy)*
7. **FERS and CSRS Offset Applicants** 7a. Has the employee made application for disability benefits from the Social Security Administration? ☐ Yes ☐ No	7b. Is the application receipt or award notice attached? ☐ Yes ☐ No	

8. Are the following documents attachments attached *(Indicate by "X" for each)*.	Yes	No	Not Applicable
a. SF 2801 or SF 3107, Application for Immediate Retirement			
b. SF 3112A, Applicant's Statement of Disability			
c. SF 3112B, Supervisor's Statement			
- Employee's Performance Standards			
- Employee's Position Description			
- Supporting documentation regarding employee's performance			
- Supporting documentation regarding employee's leave use			
- Supporting documentation regarding employee's conduct			
d. SF 3112C, Licensed Healthcare Practitioner's Statement *(or equivalent)*			
e. SF 3112D, Agency Certification of Reassignment and Accommodation Efforts			
- Supporting documentation of Agency's accommodation efforts			
- Supporting documentation of employee's non-reassignment or non-selection			
f. Agency report of Federal medical examination *(if one was made)*			
g. Other:			

9. Has the supervisor stated the employee's performance is less than fully successfully in any critical element of the position in Section B, SF 3112B?

☐ Yes ➔ (1) a copy of the employee's performance appraisal covering the employee's service prior to the date shown in Section B, item 5, of the *Supervisor's Statement*, ***and***
(2) a copy of the performance appraisal covering service after that date, if available.

☐ No

10. If the employee is temporarily at an address other than the one given on SF 2801 or SF 3107, Section A *(such as hospital, nursing home, or with a relative)*, enter that address, including ZIP Code.	11. If the employee is unable to act on his own behalf, give the name and address of the person acting for him or her.

Agency Certification

12. **I *certify* that the information shown above accurately reflects verified information in official records.**	13. Full Agency name and address *(including ZIP Code)*
12a. Signature of Chief Personnel Officer or Designee	
12b. Official Title	14. List the full name and address of agency office and official to be notified of OPM's determination *(including telephone number and area code)*.
12c. E-mail address	
12d. Telephone number *(incl. area code)* / 12d. Date *(mm/dd/yyyy)*	☐ Check here if this address is the same as the address in item 13.