

Application Form for Medical Discharge Benefit (s.8 & s.10B(1))

Please print clearly in black ink.

Member number	Registered number
<input type="text"/>	<input type="text"/>
Member's Given name(s)	
<input type="text"/>	
Member's Family name	
<input type="text"/>	

Who should use this form?

This form can only be signed and submitted by the Police Commissioner or his delegate under s15B of the *Police Regulation (Superannuation) Act 1906* (PRSA) ("Delegate") in respect of a Member of the Police Force ("Member") who satisfies the provisions of s15B of the PRSA and whose medical discharge is being sought by the NSW Police Force.

This application may be made on behalf of the Member with or without the consent of the Member. Any information provided with the application, including personal and health information, may be provided with or without the consent of the Member as permitted under s15B of the PRSA.

The application can be made in respect of a Member who satisfies all of the following. The Member:

1. joined the Police Force before 1 April 1988,
2. is still in the Police Force, and
3. is a contributor to the PSS.

Completing this form

This Application Form contains two types of questions:

- the first asks for a box to be marked with a cross or tick
- the second asks that short answers be provided in the space on the form.

If there is insufficient space on the Form for the answer, the information can be provided on a separate sheet of paper, marking it with the relevant question number.

Unless indicated otherwise, STC requires all the information sought in this Application Form in order to determine the Member's entitlement. If all the questions are not answered, the Member's entitlement may not have been established.

Please complete all the questions to the fullest extent possible and supply as much of the information as possible to assist the processing of the application. If any of the questions cannot be answered, please explain why or ask for assistance from *Mercer*. If it is necessary for *Mercer* to request further information, processing of the application will be delayed.

Notes for PSS Form 15B

Included in the PSS Form 11 "*Application for Medical Discharge Benefit (s.8 & s.10B(1))*" are notes that assist with completing the form. (PSS Form 11 is completed by the member when applying for medical discharge) These notes can also be read to assist with completing this PSS Form 15B. The question numbers in this Application form align with the question numbers in the PSS Form 11. Please read the notes carefully and refer to them when filling in this form. The Notes explain in more detail what information is required in the answers to the questions.

Where this sign is next to a question in the Form, it indicates that there is a Note for that question.

Some terms in this Application Form are in *italics*. The Notes explain those italicised terms under the heading "**Glossary of Terms**".

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercerc.com

Checklist

Use this checklist to make sure this Application Form is complete before you lodge it with *Mercer*.

Check that ...

- the name and registered number of the Member is on the front page of the Application Form,
- all the questions have been completed,
- the declaration has been completed, signed and dated in Part G,
- copies of separate pages providing answers to questions are attached (please mark as *appropriate*):
 - Q 13 Q 14 Q 15 Q 16
 - Q 17 Q 18 Q 19 Q 21

- where relevant, attach a copy of:
 - Medical reports (Q17)
 - Clinical notes & sick leave records (Q18)
 - Rehabilitation report (Q19)
- a copy of the completed Application Form and documents have been kept for your records and have been provided to the Member.

Lodging the Application Form

Send the **original** completed Application Form and **copies** of all other supporting documents to:

State Super (PSS)
GPO Box 2181
Melbourne VIC 3001

A. Personal details of Member

1. Rank

2. Family name

3. Given name(s)

4. Registered number 5. Birth date (DD-MM-YYYY)
 - -

B. Contact details of Member

6. Address: Street number and name

Suburb State/Territory Postcode

Postal address: PO Box / Street number and name (if different from residential address)

Suburb State/Territory Postcode

7. Email address (optional)

8. Daytime contact telephone number Work or Home

Mobile number

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

9. Alternative contact name (optional) ⓘ

Form field for alternative contact name

Alternative contact telephone number (optional) ⓘ

Form field for alternative contact telephone number

C. Member's eligibility

10. Attestation date when first joined Police Force (DD-MM-YYYY)

Form field for attestation date (DD-MM-YYYY)

11. Is the member a contributor to the PSS? ⓘ

Yes No - If no, this form should not be completed.

12. Are any of the injuries referred to in this application claimed or assessed as HOD?

Yes No

13. Please provide the following about any previous applications made in respect of the Member for any lump sum compensation for an HOD injury (if known). ⓘ

(a) Benefit applied for	(b) Date of application (approximately)

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

D. Work and Medical information

14. Is the member currently incapable of discharging full operational duties? ⓘ

Yes No

If yes, what medical condition/s caused or contributed to that incapacity?

Medical Condition 1:
Medical Condition 2:
Medical Condition 3:

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

15. Describe the duties the Member is unable to perform because of any medical condition identified in the answer to Q14 and explain why the member cannot perform these duties. ⓘ

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

16. For each medical condition identified in the answer to Q14, please provide the following information about the injuries causing the medical condition. ⓘ

MEDICAL CONDITION 1

INJURY 1

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (approximately) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (approximately)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

MEDICAL CONDITION 1

INJURY 2

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (*approximately*) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (*approximately*)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 1

INJURY 3

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (*approximately*) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (*approximately*)

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon-Fri on (02) 4298 6016 or email

STC_employer@mercero.com

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 2

INJURY 1

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (approximately) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (approximately)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 2

INJURY 2

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (approximately) (DD-MM-YYYY) - -

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon-Fri on (02) 4298 6016 or email

STC_employer@mercero.com

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (approximately)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 2

INJURY 3

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (*approximately*) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (approximately)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

MEDICAL CONDITION 3

INJURY 1

- a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

- b) Date of injury (*approximately*) (DD-MM-YYYY)

 - -

- c) Is the injury HOD? Yes No Not yet assessed

- d) Describe the circumstance in which the injury occurred

- e) Indicate any period/s of sick leave taken following the injury and the dates (*approximately*)

- f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

- g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 3

INJURY 2

- a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

- b) Date of injury (*approximately*) (DD-MM-YYYY)

 - -

- c) Is the injury HOD? Yes No Not yet assessed

- d) Describe the circumstance in which the injury occurred

- e) Indicate any period/s of sick leave taken following the injury and the dates (*approximately*)

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

MEDICAL CONDITION 3

INJURY 3

a) Describe the injury (whether or not work related) you understand is causing or contributing to the medical condition of the Member.

b) Date of injury (approximately) (DD-MM-YYYY) - -

c) Is the injury HOD? Yes No Not yet assessed

d) Describe the circumstance in which the injury occurred

e) Indicate any period/s of sick leave taken following the injury and the dates (approximately)

f) Did the member return to work following the injury? Yes No

If yes, indicate if the duties the Member returned to were then restricted in any way because of the injury and how they were restricted.

g) Is the member currently on sick leave? Yes No If yes, please provide details.

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email

STC_employer@mercero.com

E. Medical information

17. Are any medical report/s being provided with the application?

Yes No If yes, please list the medical report.

Name of Doctor	Speciality (e.g. orthopaedic surgeon)	Date of report (dd/mm/yyyy)

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

18. Are any Police Medical Officer clinical notes or sick leave records being provided with this application?

Yes No

19. Did the Member participate in any rehabilitation or injury management program? [i](#)

Yes No

If yes, please provide details and enclose a copy of any report.

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

F. Member's involvement

20. Section 15B of the PRSA requires a copy of this Application to be provided to the Member, who has 28 days in which to notify the Commissioner of any other infirmities to be included in the Application.

Please indicate the date on which this Application was provided to the Member.

- - (DD-MM-YYYY)

Please indicate the date on which the Member responded with information to be included in the Application.

- - (DD-MM-YYYY)

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon-Fri on (02) 4298 6016 or email

STC_employer@mercero.com

21. Did the Member notify any additional infirmities to be included in the Application?

Yes No

If yes, please provide the following information in respect of each infirmity.

Identify the additional infirmities notified by the Member	Has the infirmity been determined as HOD?	If not determined as HOD, has the Member applied for the infirmity to be determined as HOD?	Please indicate any medical evidence that is available that relates to the infirmity identified by the Member

If there is insufficient space for the answer, provide the information required on a separate sheet of paper, marking it with the relevant question number.

22. Did the Member advise that one or more of the injuries listed in Q.16 are considered (by the Member) to be HOD?

Yes No

If yes, please indicate those injuries below (whether or not they have been assessed as HOD).

23. If the Member notified any additional infirmities (Q21), please indicate the date on which a copy of the revised Application was provided to the Member.

- - (DD-MM-YYYY)

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon–Fri on (02) 4298 6016 or email STC_employer@mercero.com

G. Details of Delegate

Rank

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Family name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Given name(s)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Contact telephone number (daytime)

--	--	--	--	--	--	--	--	--	--	--	--

Contact telephone number (mobile)

--	--	--	--	--	--	--	--	--	--	--	--

Email address (optional)

Declaration (by the Delegate)

I, (print name)

- (a) declare that I am a duly authorised delegate of the Police Commissioner in accordance with the NSWPF Nomination for Medical Discharge Guidelines to be used in respect of s15B of the *Police Regulation (Superannuation) Act 1906*,
- (b) declare that I have read and understood the requirements of s15B of the *Police Regulation (Superannuation) Act 1906*,
- (c) declare that the information contained in this Application conforms with the requirements of s15B of the *Police Regulation (Superannuation) Act 1906* and the NSWPF Nomination for Medical Discharge Guidelines,
- (d) declare that I have read this Application and that the information contained in it is, to the best of my knowledge, complete, true and correct, and
- (e) understand that giving information that I know is false or misleading is a serious offence.

Signature

--

Date (DD-MM-YYYY)

		-			-				
--	--	---	--	--	---	--	--	--	--

Please return to Page 1 for the Checklist and how to lodge this Form.

If you need help with this form

Contact your Employer Support Officer between 8:30am and 5:30pm AEST from Mon-Fri on (02) 4298 6016 or email **STC_employer@mercercor.com**