KENTUCKY RETIREMENT SYSTEMS
1260 Louisville Road · Frankfort, Kentucky 40601
kyret.ky.gov · Phone: 502-696-8800 · Fax: 502-696-8822

Print Form

Form 8102
Revised 04/2017

EMPLOYMENT AND MEDICAL STAFF REVIEW CERTIFICATION REINSTATEMENT

Member Information Please provide your Member ID or Social Security number in the Member ID box below.

Member Name:			Member ID:
Address:	City:	State:	Zip Code:

Employment Status (You must choose one):

☐ **Yes**, I have been employed (including self-employed) since the date I was approved for disability retirement benefits or since my last employment and medical staff review.

☐ **No**, I have not been employed (including self-employed) since the date I was approved for disability retirement benefits or since my last employment and medical staff review.

Certification of Employment Information

I, _____, hereby certify that the employment information provided on this form and the attached medical information are true, correct, accurate, and complete, meaning the attached information consists of **all** the existing medical information regarding the bodily injury, mental illness, or disease for which I was approved for disability retirement benefits since my last employment and medical staff review or since my benefits were terminated. I further certify that this form and the attached medical information are complete and ready to be reviewed by the medical staff.

I am aware that I am eligible to apply for the reinstatement of my disability benefits pursuant to KRS 61.615 and that I am responsible for filing supporting medical information to report my current physical and mental condition pursuant to KRS 61.610. I am also aware that by signing this certification I am certifying to Kentucky Retirement Systems that the enclosed medical records represent **all** the evaluations, examinations, and treatment I have had for the bodily injury, mental illness, or disease for which I was approved for disability retirement benefits, including all reports of diagnostic medical testing performed on me.

I am aware that if I have been employed, including self-employment, since the date I was approved for disability retirement benefits or since my last employment and medical staff review, I must also attach a detailed job description from my employer even if the position has been previously approved by Kentucky Retirement Systems.

I further acknowledge that any person who makes a false statement, report, or representation on this form is subject to criminal penalty pursuant to KRS 523.010 to 523.110.

Signature: _____

Printed Name: _____

Date: _____