# CITY OF JACKSONVILLE

CITY HALL, ST. JAMES BUILDING
117 WEST DUVAL STREET
JACKSONVILLE, FLORIDA 32202

## AFFIDAVIT OF CLAIM PURSUANT TO FLORIDA STATUTE § 112.1816
## (former employee)

**STATE OF FLORIDA )**
**)**
**COUNTY OF DUVAL )**

BEFORE ME, the undersigned authority, personally appeared, _____, who being first duly sworn, deposes and says:

1. My name is _____, I am over the age of eighteen (18) and am of sound mind. I give the following information, of which I have personal knowledge, both freely and truthfully, without any threat of coercion or promise of benefit.

2. I am a former employee of the City of Jacksonville, Jacksonville Fire and Rescue Department (JFRD). I separated from my employment with JFRD on _____ (date). My reason for separation was (check one) ___ termination; ___ resignation; ___ retirement. At the time of my separation, my job title was _____.

INIT_____ 3. At the time of my separation, I had been employed with JFRD continuously for over five (5) years. My primary responsibilities during my employment with JFRD were the prevention and extinguishing of fires; the protection of life and property; and the enforcement of municipal, county, and state fire prevention codes and laws pertaining to the prevention and control of fires.

INIT_____ 4. I have not used any tobacco products during the past five (5) years.

INIT_____ 5. I have not been employed in any position in the past five (5) years which has been proven to create a higher risk for any cancer. I have not worked as a firefighter in any capacity since I separated from the JFRD.

6. I have been diagnosed with _____ (type of cancer) cancer by _____ (name of diagnosing physician). I was officially diagnosed on _____ (date of original diagnosis).

7. I ☐ have ☐ do not have a history of cancer. Type of cancer: _____ _____. Date of original diagnosis:_____

INIT_____ 8. I agree that I will not seek reimbursement from the City of Jacksonville for any prescription drug coinsurance cost for which I have also been paid, or requested payable, under a separate copy assistance card, copy savings program, copay coupon, or other patient assistance program not provided through the City of Jacksonville; or reimbursement of copays, deductibles or coinsurance for which I have also been paid, or requested payable, under a coordination of benefits as a dependent covered on a secondary basis or by any insurance other than that provided by the City of Jacksonville.

INIT_____ 9. I agree that I will provide all medical documentation requested by the City of Jacksonville regarding my diagnosis of cancer and the treatment thereof, including a medical certification from my health care provider and documentation of expenses for which I seek reimbursement from the City of Jacksonville.

INIT_____ 10. I agree that I will be truthful and forthright regarding my claim for benefits for my cancer diagnosis and/or treatment, under Florida Statute § 112.1816.

_____
Signature of Employee/Claimant

**STATE OF FLORIDA**
**COUNTY OF DUVAL**

The foregoing instrument was acknowledged before me on this ____ day of _____, 20___, by _____, who is personally known to me or who produced _____ as identification and who did take an oath.

_____
NOTARY PUBLIC, State of Florida