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|  |  | | | | | | |  | FICHE DE SAISINE DE LA COMMISSION DE RÉFORME | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | |  |
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|  | **IMPORTANT** : Afin de permettre l’instruction de la demande, **l’ensemble des champs doivent obligatoirement être renseignés** et les **pièces demandées jointes au dossier**. En cas d’incomplétude de la saisine, celle-ci vous sera retournée pour compléments. Dans l’attente, l’instruction ne pourra débuter. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |
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|  | **Renseignements concernant l’agent** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Madame | | | | | | |  |  | Monsieur | | | | | | |  |  |  |  |  | Adresse : | | | | | | | |  | | | | | | | | | | | |  |
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|  | Nom d’usage : | | | | | | |  | | | | | | | | | | | |  |  | Complément : | | | | | | | |  | | | | | | | | | | | |  |
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|  | Prénom(s) : | | | | | | |  | | | | | | | | | | | |  |  | Code postal : | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Date de naissance : | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Ville : | | | | | | | |  | | | | | | | | | | | |  |
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|  | Statut applicable : | | | | | | |  | Titulaire | | | | | |  | Stagiaire | | | | | |  | | Ouvrier d’état | | | | | |  |  | | | | | |  |  |  |  |  |  |
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|  | Fonction publique : | | | | | | |  | Etat | | | | | |  | Territoriale | | | | | |  | | Hospitalière | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Corps : | | | | | | |  | | | | | | | | | | | |  |  | Grade : | | | | | | | |  | | | | | | | | | | | |  |
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|  | Entrée dans l’Adm. : | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Titularisation : | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Renseignements concernant le service en charge du dossier** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Entité juridique\* : | | | | | | |  | | | | | | | | | | | |  |  | Service RH\*\*\* : | | | | | | |  | | | | | | | | | | | |  |
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|  | Structure\*\* : | | | | | | |  | | | | | | | | | | | |  |  | Nom du référent : | | | | | | |  | | | | | | | | | | | |  |
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|  | Complément : | | | | | | |  | | | | | | | | | | | |  |  | Courriel : | | | | | | |  | | | | | | | | | | | |  |
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|  | Code postal : | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \*Entité juridique de rattachement : Agriculture, Culture, Défense, Economie, Santé, Travail, Justice, etc.  \*\*Structure d’affectation : Agence de santé, Centre hospitalier, etc.  \*\*\*Service RH : en charge de la gestion du dossier médical de l’agent | | | | | | | | | | | | | | | | | | |  |
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|  | **Renseignements concernant la maladie ou l’accident** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | Maladie professionnelle n° : | | | | | | | | | | |  | | |  |  | Du : | |  |  |  |  |  |  |  | |  | |  | | déjà reconnue : | | | | | | | | | | | |  | |  | | Oui | | | |  | | Non | | | |  | |
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|  | Maladie contractée en service : | | | | | | | | | | | | | |  |  | Du : | |  |  |  |  |  |  |  | |  | |  | | déjà reconnue : | | | | | | | | | | | |  | |  | | Oui | | | |  | | Non | | | |  | |
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|  | Accident de service ou trajet : | | | | | | | | | | | | | |  |  | Du : | |  |  |  |  |  |  |  | |  | |  | | déjà reconnue : | | | | | | | | | | | |  | |  | | Oui | | | |  | | Non | | | |  | |
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|  | Si reconnaissance, date de reconnaissance : | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |
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|  |  | Directement par l’administration | | | | | | | | | | | | |  |  |  | Après avis de la comission du : | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |

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|  | **Renseignements concernant le médecin de prévention** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Nom du médecin : | | | | | | |  | | | | | | | | | | | |  |  | Code postal : | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Complément : | | | | | | |  | | | | | | | | | | | |  |  |  | | | | | | |  | | | | | | | | | | | |  |
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|  | **Renseignements concernant la demande** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  |  | Accident de service ou accident de trajet : | | | | | | | | | | | | | | | | | | |  |  | Maladies professionnelles : | | | | | | | | | | | | | | | | | | |
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|  |  |  |  | Reconnaissance | | | | | | |  |  | Rechute | | | | | | |  |  |  |  |  | Reconnaissance | | | | | | |  |  | Rechute | | | | | | |  |
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|  |  | Demande de prise en charge ou prolongation d’arrêts | | | | | | | | | | | | | | | | | | |  |  | Demande de prise en charge ou prolongation des soins | | | | | | | | | | | | | | | | | |  |
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|  |  |  |  | Prise en charge | | | | | | |  |  | Prolongation | | | | | | |  |  |  |  |  | Prise en charge | | | | | | |  |  | Prolongation | | | | | | |  |
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|  |  | TPT : Temps partiel thérapeutique (si avis discordant) | | | | | | | | | | | | | | | | | | |  |  | Constatation de : | | | | | | | | | | | | | | | | | |  |
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|  |  |  |  | Octroi | | | | | | |  |  | Prolongation | | | | | | |  |  |  |  |  | Guérison | | | | | | |  |  | Consolidation | | | | | | |  |
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|  |  | ATI : Allocation temporaire d’invalidité | | | | | | | | | | | | | | | | | | |  |  | AIT : Allocation d’invalidité temporaire | | | | | | | | | | | | | | | | | | | |
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|  |  |  | Attribution | | | | |  | Révision quinquennale | | | | |  | Révision à radiation des cadres (RDC) | | | | |  |  |  | Retraite pour invalidité non imputable (+PCI) | | | | | | | | | | | | | | | | | | | |
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|  |  |  |  |  |  |  |  | Retraite pour invalidité imputable au service (+PCI) | | | | | | | | | | | | | | | | | | | |
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|  |  | Majoration pour assistance d’un tierce personne | | | | | | | | | | | | | | | | | | |  |  | Octroi d’une 4ème période de mise en disponibilité d’office | | | | | | | | | | | | | | | | | | | |
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|  |  | Aptitude/Inaptitude aux fonctions | | | | | | | | | | | | | | | | | | |  |  | Entrée en jouissance immédiate de la pension | | | | | | | | | | | | | | | | | | | |
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|  |  | Cure thermale | | | | | | | | | | | | | | | | | | |  |  | Autre : | | |  | | | | | | | | | | | | | | |  | |
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|  |  | Prise en charge des soins post-consolidation | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  | |
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|  | | **Renseignements concernant le(s) expertise(s)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | | Nom du médecin agréé ayant effectué : | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |
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|  | | * L’expertise : | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |
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|  | | * Une contre-expertise (option) : | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |
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|  | | *Rappel : les rapports d’expertises sont à joindre au dossier lors de la saisine de la commission* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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|  | **Renseignements concernant les représentants (à ne renseigner que lorsque l’agent relève de la FPE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | *Représentants d’administration (chef de service dont dépend l’intéressé ou son représentant)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Nom : | | | | | | | |  | | | | | | | | | | | |  |  | Courriel : | | | | | | |  | | | | | | | | | | | |  |
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|  | | *Représentant du personnel* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Nom : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | Courriel : | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Nom : | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | Courriel : | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |
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