ATTACHMENT A

THE PROPOSED DECISION

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BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Application for Disability Retirement of:

SHARON L. STEURER and CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, Respondents

Case No. 2019-0605

OAH No. 2019080478

PROPOSED DECISION

This matter was heard before Dena Coggins, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, on January 14, 2020, in Sacramento, California.

Rory Coffey, Senior Attorney, represented the California Public Employees' Retirement System (CalPERS).

Respondent Sharon L. Steurer (respondent) represented herself.

No one appeared for or on behalf of the California Department of Public Health (Department). The Department was duly served with the Notice of Hearing. The matter proceeded as a default against the Department pursuant to Government Code section 11520, subdivision (a).

PUBLIC EMPLOYEES RETIREMENT SYSTEM
FILED February 7, 20 20

Evidence was received, the record was closed, and the matter was submitted for decision on January 14, 2020.

SUMMARY

1. The sole issue on appeal is whether respondent was permanently and substantially incapacitated for the performance of her usual job duties as an Associate Governmental Program Analyst (AGPA) due to cardiologic (ventricular tachycardia) and neuropsychological conditions at the time she applied for service pending disability retirement. Respondent did not produce persuasive medical evidence establishing she was substantially incapacitated at the time she applied for disability retirement. Therefore, her application for disability retirement should be denied.

FACTUAL FINDINGS

Procedural Background

2. On November 19, 2019, respondent signed and CalPERS subsequently received, respondent's Disability Retirement Election Application for Service Pending Disability Retirement (application). Respondent identified her specific disabilities on the application as "cognitive deficit in psychomotor function, anoxic encephalopathy status post ventricular fibrillation cardiac arrest." She noted on the application that her disabilities resulted from a cardiac arrest. She wrote that her injury affected her ability to perform her job because of:

> [D]ifficulty with attention distractibility, difficulty concentrating, memory (forgetting what I am talking about

> as I am talking, forgetting what I was going to do, forget [*sic*] information discussed in conversations, misplacing items), language (word finding, [i]ncorrect sequencing of words, occasional stuttering)

3. CalPERS notified respondent by correspondence, dated May 16, 2019, that her application was being denied based upon CalPERS's staff review of medical reports, which included reports prepared by Kimberly Lanni, Ph.D., Quynh Huong Vu Pham, M.D., and Charles Filanosky, Jr., Ph.D. Respondent timely appealed CalPERS's denial. On July 24, 2019, Keith Riddle, Chief of CalPERS's Disability and Survivor Benefits Division, signed and thereafter filed the Statement of Issues solely in his official capacity.

Employment History

4. At the time she filed her application for disability retirement, respondent was an AGPA at the California Department of Public Health. Her last day on payroll was November 19, 2018, and her retirement date was November 20, 2019.

Duties of an Associate Governmental Program Analyst

5. A job description for the position of an AGPA identifies the "essential functions" as follows, in relevant part:

> 35% Independently conducts unannounced onsite audits of healthcare facilities to evaluate, identify, document and report compliance with state and federal licensing and certification regulations related to nursing staff[.] Conducts comparative analyses of healthcare facility staffing practices

by analyzing and interpreting complex payroll personnel, staff scheduling and patient census data[.] Applies policies and procedures and regulatory requirements to make critical determinations regarding health care facility non-compliance with state and federal regulations that may result in monetary fines or other enforcement actions[.] Updates various federal[,] state and departmental electronic databases . . . which are utilized to maintain sensitive data related to healthcare facility compliance with mandated healthcare delivery standards[.]

[2]5%[1] Functions as a departmental representative, liaison and subject-matter expert for the Data Management Unit[.] Maintains professional and diplomatic verbal and written communication with varied entities, including but not limited to healthcare facility representatives and departmental staff[.] Conducts entrance conferences with healthcare facility corporate and managerial staff[.] Conducts recorded exit conferences with healthcare facility corporate and managerial staff and departmental survey team members. Provides technical consultative assistance to

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[1] The Duty Statement that is in evidence appears to have a typographical error relating to the percent of time required for this essential duty. A reasonable inference was made that the percent of time is 25 percent based upon the percent of time allotted to the other essential functions.

healthcare facility and survey team staff pertaining to the health facility staffing portion of the survey process[.] Communicates professionally and effectively with healthcare facility staff to resolve discrepancies or disputes with audit processes or findings[.] Composes timely complex and sensitive correspondence . . . to facilities and departmental agencies to document violations . . .

10% Identifies and analyzes problems and issues related to unit policies and procedures[,] determines program operational needs and requirements[,] and recommends effective action for improvement[.] . . . Responds to requests for detailed and comprehensive statistics and information regarding healthcare facility staffing compliance levels and related data collected through the audit process reporting[.] . . . .

10% Attends and presents both written and verbal testimony to provide support for civil monetary penalties, informal conferences[,] citation review conferences, evidentiary hearings, informal dispute resolutions, municipal or superior court proceedings and arbitration proceedings[.] Responds to these legal actions as an expert witness on matters relating to State and Federal laws and regulations pertaining to staffing of healthcare facilities. . . .

WORK ENVIRONMENT PHYSICAL OR MENTAL ABILITIES Extensive travel to various healthcare facilities in order to

> conduct staff audits including some overnight travel and drive distances of over 200 miles per day[.] . . . Ability to think and reason in analyzing quantitative and qualitative information[.] Efficiently perform assigned tasks under demanding and competing deadlines[.] Ability to communicate effectively and clearly express ideas or facts both orally and in writing[.] Ability to interpret and comprehend both written and oral information necessary to perform assigned tasks and complete assigned objectives[.]

CalPERS's Evidence

Dr. McHenry's Evaluation of Respondent

6. CalPERS's requested Malcom McHenry, M.D., perform an independent medical examination (IME) of respondent. Dr. McHenry is board-certified in internal medicine with a subspecialty in cardiovascular medicine. He is currently the Director of the Emergency Medical Care Unit for the California State Legislature and an Adjunct Professor of Electrical Engineering at California State University, Sacramento. He was a senior adult cardiologist at Sutter Community Hospital for 37 years and had a private practice in adult cardiology for 50 years. He has written numerous publications on cardiovascular issues. Dr. McHenry testified at the hearing.

7. Dr. McHenry evaluated respondent on March 4, 2019. He prepared a report documenting his IME on March 12, 2019. As part of respondent's IME, Dr. McHenry interviewed respondent, obtained a work and employment history, and conducted a physical examination. Dr. McHenry reviewed the duty statement for

respondent's position as an AGPA, respondent's medical records, and spoke with respondent's husband, Christopher Steurer.

8. Respondent provided Dr. McHenry with information about her medical history, including information on her cardiac arrest due to ventricular fibrillation that occurred on November 18, 2017, and her subsequent treatment history. Dr. McHenry summarized respondent's November 18, 2017 cardiac event as follows:

> [Respondent] had no prior cardiac history until November 18, 2017. She was at home in bed. Her husband was in the bathroom when he heard a crash. He came out and found her in the bed with glass all over her face. He picked glass out of her mouth, off her face, and out of her eyes. She had apparently knocked over a glass candlestick. He noted that there was no response to him and that she was unconscious and he called 911.
>
> The paramedics arrived within about five minutes. . . .
>
> The paramedics found her to be in ventricular fibrillation and gave her a single DC counter-shock which returned her to sinus rhythm and returned her circulation such that pulses were now felt.
>
> [Respondent] was transferred to Mather Hospital where a CT of the brain was performed and was said to be normal.

9. In November 2017, respondent underwent an implantation of a Boston Scientific Dynagen, single lead, intracardiac defibrillator without incident at Mercy

General Hospital. In the same month, respondent was transferred to Kaiser North Hospital and seen by Dr. Eric Van Ostrand. In December 2017, Dr. Van Ostrand noted that respondent's short-term recall was still impaired. He made the diagnosis of a hypoxic encephalopathy following ventricular fibrillation induced cardiac arrest and believed she would need neuropsychological testing prior to returning to work. Dr. William Phillips subsequently assumed respondent's care at Kaiser, and in January 2018, he interpreted a repeat echocardiogram. He found mild left ventricular hypertrophy. Respondent's left ventricular size was normal and there was normal diastolic left ventricular function. Pulmonary artery pressure and right heart filling pressures were normal. Dr. Phillips found the echocardiogram showed significant improvement over the prior November 2017 echocardiogram. Respondent received care from the Outpatient Device Clinic at Kaiser.

10. In March, April, and May 2018, respondent had three episodes of non-sustained ventricular tachycardia at rates of 186, 255, and 186 beats per minute, respectively. In June 2018, respondent had an "eight-beat run of non-sustained ventricular tachycardia" at a rate of 207 beats per minute. Since her defibrillator was implanted, she had "one single episode of sudden presyncope" at home, but she did not recall the date.

11. Respondent told Dr. McHenry that she took a service retirement because she did not believe she could carry out the cognitive aspects of her job as an AGPA. Specifically, respondent informed Dr. McHenry that she no longer drives, is forgetful and cannot remember where she is going. She further stated she fragments sentences, she does not believe she would be able to carry out an exit interview with an administrator of a nursing facility, she cannot respond to rapid back-and-forth questions, and she becomes easily distracted. Moreover, respondent expressed to Dr.

McHenry she is fearful of returning to work, cannot continue the performance levels she achieved before, and cannot attend court hearings.

12. Dr. McHenry summarized respondent's diagnoses as follows:

1. Probable dilated cardiomyopathy.
2. Out-of-hospital cardiac arrest due to ventricular fibrillation.
3. Automatic internal cardiac defibrillator implantation.
4. Longstanding bronchial asthma with dyspnea.
5. Ulcerative colitis.
6. Anoxic encephalopathy with cognitive defects.
7. Recurrent short-lived runs of asymptomatic ventricular tachycardia.
8. Depression.
9. Edema due to venous insufficiency of the lower extremities.

13. Dr. McHenry performed an electrocardiogram on respondent with a "normal" result. Dr. McHenry wrote in his IME report:

> I am concerned about the several episodes of short-lived, non-sustained ventricular tachycardia which have been shown on interrogation of her defibrillator. This raises the issue as to whether, in the future, another cardiac arrhythmia might occur. Treatment with an anti-arrhythmic agent, specifically amiodarone, on a maintenance basis,

> might be indicated to protect her from the long-term adverse effects of recurrent sustained ventricular arrhythmias.

14. In response to CalPERS's question of whether respondent has an actual and present cardiology (ventricular fibrillation cardiac arrest) impairment that rises to the level of substantial incapacity to perform her usual job duties, Dr. McHenry wrote:

> [Respondent] does not have an actual, present cardiology impairment that arises to the level of substantial incapacity. She would be protected by her implanted defibrillator if sustained ventricular tachycardia occurred.

The lack of objective findings that lead Dr. McHenry to conclude that respondent is not substantially incapacitated was that she had no recurrent sustained symptomatic arrhythmia since her cardiac arrest.

DR. FILANOSKY'S EVALUATION OF RESPONDENT

15. CalPERS requested Charles A. Filanosky, Ph.D., perform a Neuropsychological Independent Evaluation of respondent. He has a bachelor's degree in psychology, a master's degree in education and science, a certificate in neuropsychological assessment, and a doctorate degree in clinical psychology. He has been a staff neuropsychologist at The Permanente Medical Group since 2016. He was previously employed as a staff psychologist/program lead at the Veterans Affairs Medical Center from 2007 to 2016. He also maintains a private practice as a rehabilitation neuropsychologist. From 2007 to 2016, he was an associate clinical professor in the Department of Psychiatry at the University of California, San Francisco. He is licensed to practice in psychology in California and Michigan. He has presented

on the topic of screening for cognitive impairment, evaluating capacity in older adults, and neuropsychological assessment, among many other topics in his practice area. Dr. Filanosky testified at the hearing.

16. Dr. Filanosky evaluated respondent on April 18, 2019, and prepared a report documenting the evaluation. As part of his evaluation, Dr. Filanosky reviewed respondent's medical records. In his report, Dr. Filanosky described respondent's relevant past medical history, including her cardiac arrest on November 18, 2017. Dr. Filanosky noted that respondent recovered consciousness following her cardiac arrest, although she remained amnestic for the event and confused when recognizing family members. By day four, respondent's memory was noted to be improved. Respondent was referred to neurology in November 2017, because of concerns about memory loss and dizziness. In January 2018, respondent felt "less sharp mentally" and two months later she continued to have short-term memory issues. In April 2018, Dr. Lanni performed neuropsychological testing on respondent. A full battery was completed; respondent's performance was described as slowed but overall accurate. Dr. Lanni noted, "Otherwise her ability to learn and recall new information, executive functions, language, visual spatial skills, and basic auditory and visual attention are within normal limits and comparable to her baseline." Dr. Lanni considered anxiety, alcohol use, cannabis use, and poor sleep as potentially contributory, and recommended mental health treatment, use of compensatory strategies, and a behind the wheel driving test.

17. Dr. Filanosky performed a mental status examination on respondent. He noted that her cognition appeared "grossly intact" and her judgment and insight appeared "to be within broadly normal limits." Dr. Filanosky administered the DKEFS Trail Making Subtest; Wechsler Memory Scale, Fourth Edition: Brief Cognitive Status

Exam, Logical Memory; Verbal Paired Associates, Visual Reproduction, and Spatial Addition; and Wechsler Adult Intelligence Scale, Fourth Edition.

Respondent's test results showed that her visual attention for discrimination of detail was average and within normal limits, her ability to listen and repeat back strings of numbers of increasing complexity and auditory attention performance was average. Her general intellectual ability is high average, which is not considered to be a significant change. She has superior perceptual reasoning and high average processing speed. Her verbal comprehension abilities and working memory/concentration are also "solidly average." Although her overall memory was "somewhat variable," all performance was at least average with some abilities "even better." Dr. Filanosky did not observe impairment that would substantially impact day-to-day functioning. Respondent had intact basic receptive and expressive language abilities, and was able to read and comprehend test directions. She had mild stuttering that was intermittent and typically diminished once she was engaged in a task. She struggled "sometimes" with word precision, but her struggles did not impact her communication abilities. Her verbal comprehension skills were assessed as average. She performed in the high average range in her ability to attend to arithmetic word problems, translate word problems to mathematical operations, and then solve them accurately without writing the operations down. Her test results suggested "well retained ability to understand connections, and cause and effect types of relationships." She evidenced "good" task perseverance, no observed atypical impulsivity such as initiating a response before directions were completed and no violations of test rules. Respondent's ability to rapidly change mental set was "a little slowed" with no errors noted, which indicated to Dr. Filanosky that she displayed an appropriate strategy of slowing down to optimize accuracy.

18. Dr. Filanosky found respondent to have some variability in her cognitive function, but largely within normal limits and expectations, which is consistent with Dr. Lanni's previous testing of respondent. Dr. Filanosky opined that respondent "more likely than not has some mild, inconsistent residual cognitive symptoms" resulting from her cardiac arrest that appear to be more "language based and some subtle communication difficulties." Dr. Filanosky noted, "These deficits, where present, can be characterized typically as a drop from superior to high average or from high average functioning to average functioning." He further stated, "[T]hese [deficits] would not be expected to be [*sic*] substantially interfering [*sic*] in the routine tasks of day to day living."

Dr. Filanosky found that relating to respondent's work function, generally, her ability to perform tasks from a cognitive standpoint "is considered preserved." Her cognition is intact. Overall, "performance is generally consistent with expectations, possibly just a subtle dip below in some select areas, given previous levels of academic attainment and professional achievement." Dr. Filanosky diagnosed respondent with Mild Neurocognitive Disorder due to anoxic injury, r/o Cannabis use disorder.

19. In response to CalPERS's question of whether respondent has an actual and present neuropsychological cognitive deficit status-post anoxic injury impairment that rises to the level of substantial incapacity to perform her usual job duties, Dr. Filanosky wrote:

> It is my opinion based on the findings of this examination . . . that some mild residual neuropsychological deficits are present in this specific case. While it is expected that they may potentially lead to some increased inefficiency it is not expected that they are of sufficient magnitude as to prevent

> [respondent] from being able to perform basic job duties as outlined in her provided and reviewed job description.

The objective findings (or lack thereof) that lead Dr. Filanosky to conclude that respondent is not substantially incapacitated was her previous neuropsychological testing results showing she was in normal limits. Additionally, her performance during Dr. Filanosky's evaluation showed her performance to be typically average if not higher across all domains assessed. She had average if not better abilities on the standardized objective measures used in the evaluation. Dr. Filanosky had had no opinion regarding her ability to drive. Dr. Filanosky wrote in his report:

> [Respondent's] condition is not substantially incapacitating from a neuropsychological perspective. The medical record suggests at least for some period some temporary disability was present. Cognitive difficulties were noted at the time of the injury and immediately thereafter and cognitive problems were reported by the claimant to her treating medical providers afterward. By the time of her neuropsychological examination at Kaiser, based on the results of that examination, any significant or substantial problems had resolved.

Respondent's Evidence

20. Respondent did not call any medical experts to testify at the hearing. Respondent submitted the Sacramento Metropolitan Fire response notes relating to her cardiac arrest, the Physician's Report on Disability, and an off work letter purportedly signed and authorized by William Lee Phillips, M.D. These documents

were admitted as administrative hearsay and have been considered to the extent permitted under Government Code section 11513, subdivision (d).

21. Respondent testified at the hearing. She was employed by the State of California for 18 years. She discussed the complexities of her position as an AGPA and her love for the work she did in that position. According to respondent, her cardiac issues are "stable," but she has had several episodes of ventricular tachycardia following her November 2017 cardiac event. She believes she has physically recovered, but is concerned about her cognitive function, which includes memory loss, forgetfulness, stuttering, incorrect sequencing of words when speaking, distraction, and difficulty in multi-tasking. She is concerned that the evaluations conducted by Dr. McHenry and Dr. Filanosky are "small snapshots" of her life, and not an accurate reflection of her daily life. She does not believe she is able to perform the duties required of her as an AGPA if she returns to work.

22. Respondent's daughter, Cheryl Jenkins, testified at the hearing. She has been the primary point of contact with the Department on respondent's behalf while respondent was on medical leave. Ms. Jenkins completed the information about respondent contained in the "Member Information" section of the Physician's Report on Disability form then sent the form to Kaiser for completion. The form was completed by an individual at Kaiser and appears to have been signed on behalf of Dr. Phillips. However, it is unclear from the form if typewritten information contained in the form relating to respondent's incapacity was reviewed by and authorized by Dr. Phillips. Dr. Phillips did not testify at the hearing, so it is unclear what his opinion is as to respondent's incapacity to perform her usual duties as an AGPA, although the form indicates that respondent is substantially and permanently incapacitated from performance of her duties as an AGPA.

23. Respondent's husband, Mr. Steurer, testified at the hearing. He has been married to respondent for 41 years and was present at the time she had her cardiac event in November 2017. He has observed respondent's forgetfulness, stuttering, and anxiety since November 2017. He finds respondent to be more argumentative and "regularly mixes up words in a sentence." Mr. Steurer recalled that Dr. Phillips did not permit respondent to drive; instead, Dr. Phillips asked her to take a driving test that would be set up by the Department of Motor Vehicles (DMV). Respondent has been unable to take the driving test, because it must be set up by the DMV, and, despite respondent's attempts to set up the test herself, DMV has not scheduled the test. Respondent's driver's license expired, but her driving privileges have not been relinquished.

Discussion

24. Respondent has the burden of producing sufficient competent medical evidence to establish she was substantially incapacitated for the performance of her usual duties as an AGPA with the Department at the time she applied for disability retirement. When all the evidence is considered, she did not meet his burden. Respondent called no medical expert witnesses to testify at hearing, and her medical evidence consisted of response notes from the Sacramento Metropolitan Fire response notes relating to her cardiac arrest, a Physician's Report on Disability dated December 20, 2018, and a letter placing her off work until November 30, 2018. Little weight is given to the Physician's Report on Disability submitted by respondent, as it is unclear who the individual is who prepared the document, whether the document was reviewed by Dr. Phillips, and whether the form contains Dr. Phillips' medical opinions of respondent and her ability to perform the duties of an AGPA. Dr. Phillips did not testify at hearing to establish the evidence he believed showed respondent was

substantially incapacitated from the performance of her usual job duties, if that is in fact his opinion. Consequently, respondent failed to establish that her disability retirement application should be granted based upon the evidence submitted.

25. Dr. McHenry's opinion that respondent does not have an actual, present cardiology impairment that rises to the level of substantial incapacity to perform her usual job duties as an AGPA based on the evidence he reviewed was persuasive. Dr. McHenry based his opinions on his review of the duty statement of respondent's position as an AGPA, review of respondent's medical records, and a physical examination of respondent. Based on his review and evaluation, Dr. McHenry opined that respondent would be protected by her implanted defibrillator if sustained ventricular tachycardia occurred. The objective findings that led Dr. McHenry to the conclusion that respondent is not substantially incapacitated was that she had no recurrent sustained symptomatic arrhythmia since her cardiac arrest. Dr. McHenry's report and hearing testimony were comprehensive and detailed, and he persuasively explained why respondent is not substantially incapacitated from the performance of her usual and customary duties as an AGPA because of a cardiology impairment.

26. Dr. Filanosky's opinion that respondent does not have an actual and present neuropsychological cognitive deficit status-post anoxic injury impairment that rises to the level of substantial incapacity to perform her usual job duties was equally persuasive. Dr. Filanosky based his opinion on his review of her job duties as an AGPA, review of respondent's medical records, and a neuropsychological independent evaluation of respondent that included administering numerous tests to respondent. Dr. Filanosky found that respondent was not substantially incapacitated to perform her usual job duties based on neuropsychological testing that was largely described as being within normal limits and an average and higher examination performance across

all domains assessed. He acknowledged that some mild residual neuropsychological deficits were present and may potentially lead to some increased inefficiency; however, he persuasively opined that those deficits are not of a sufficient magnitude to prevent respondent from being able to perform her usual job duties. Dr. Filanosky's report and hearing testimony were comprehensive and detailed. He persuasively explained why respondent is not substantially incapacitated from the performance of her usual job duties as an AGPA because of neuropsychological cognitive deficit status-post anoxic impairment.

LEGAL CONCLUSIONS

1. To qualify for disability retirement, respondent must prove that at the time she applied, she was "incapacitated physically or mentally for the performance of his or her duties . . ." (Gov. Code, § 21156, subd. (a)(1).) As defined in Government Code section 20026:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board . . . on the basis of competent medical opinion.

2. Government Code section 21156, subdivision (a), provides, in pertinent part:

> (1) If the medical examination and other available information show to the satisfaction of the board . . . that the member in the state service is incapacitated physically

> or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability . . . .
>
> (2) In determining whether a member is eligible to retire for disability, the board . . . shall make a determination on the basis of competent medical opinion and shall not use disability retirement as a substitute for the disciplinary process.

3. The courts have interpreted the phrase "incapacitated for the performance of duty" to mean "the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) It is not necessary that the person be able to perform any and all duties since public policy supports employment and utilization of the disabled. (*Schrier v. San Mateo County Employees' Retirement Association* (1983) 142 Cal.App.3d 957, 961-962.) Instead, the frequency with which the duties she cannot perform are usually performed as well as the general composition of duties she can perform must be considered. (*Mansperger v. Public Employees' Retirement System*, *supra*, 6 Cal.App.3d at pp. 876-877 [while applicant was unable to lift or carry heavy objects due to his disability, "the necessity that a fish and game warden carry off a heavy object alone is a remote occurrence"].)

4. The burden of proof was on respondent to demonstrate that she is permanently and substantially unable to perform his usual duties such that she is permanently disabled. (*Harmon v. Bd. of Retirement of San Mateo County*, (1976) 62 Cal.App.3d 689, 691; *Glover v. Bd. of Retirement* (1980) 214 Cal. App.3d 1327, 1332.) To meet this burden, respondent must submit competent, objective medical evidence to

establish that, at the time of her application she was permanently disabled or incapacitated from performing the usual duties of her position. (*Harmon v. Board of Retirement*, *supra*, 62 Cal.App.3d at p. 697.)

5. Respondent did not produce sufficient persuasive medical evidence to establish she was substantially incapacitated for the performance of her usual duties as an AGPA with the Department due to cardiologic (ventricular tachycardia) and neuropsychological conditions when she applied for disability retirement. Therefore, based on the Factual Findings and Legal Conclusions, her Disability Retirement Election Application for Service Pending Disability Retirement should be denied.

ORDER

Respondent Sharon L. Steurer's application for disability retirement is DENIED.

DATE: February 6, 2020

DocuSigned by:

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DENA COGGINS

Administrative Law Judge

Office of Administrative Hearings