IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY ANNUITY TRUST

PO Box 398 | Dayton, Ohio 45401-0398
Toll Free: 800-331-4277 | Fax: 937-454-5457

DISABILITY ANNUITY EXAMINATION REPORT

TO BE COMPLETED BY DISABLING PHYSICIAN (MUST BE AN M.D. OR A D.O.)

Please print or type. This form MUST be returned with the Annuity Application.

Patient's Name: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Social Security Number: _____-_____-_____ Union Book No.: _____ Local No.: _____

Date of most recent examination: _____/_____/_____

As a result of my examination: ☐ I find patient to be ☐ I find patient NOT to be

Totally and permanently disabled; and his/her disability; in accordance with the following definition, is of such a nature that it presumably will be permanent and continuous for the balance of his/her life.

(a) "He/she has been totally disabled by bodily injury or disease; so as to be prevented thereby from engaging in further work as an Iron Worker or as any other type of Building Trades Craftsman; and"

(b) "Such disability will be permanent and continuous for the remainder of his/her life."

My opinion is based on the following:

Diagnosis:

_____

_____

History:

_____

_____

Date you examined and determined patient to be totally and permanently disabled:_____/_____/_____

Is Medical Treatment required at the present time?: ☐ Yes ☐ No

I recommend re-examination in approximately: _____

Date patient first consulted you for this condition: _____/_____/_____

Date of treatments and/or examinations within the past 12 months: _____

_____

Remarks (use reverse side if more space is needed): _____

_____

_____

Physician's Name: _____Street Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Degree: _____

Date Signed: _____/_____/_____