IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY PENSION TRUST

P.O. Box 398 • Dayton, Ohio 45401 – 0398

Toll Free: 800.331.4277 Fax: 937.454.5457

DISABILITY PENSION 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 your Pension Application.

Patient's Name: _____
Street Address: _____

City:_____ State: _____ Zip: _____

Social Security No.: _____-____-_____ 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 disability; in accordance with the following definition, is of such a nature that it presumable will be permanent and continuous for the balance of his life.

(a) "He 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 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: _____
(Only an M.D. or D.O. will be accepted)

Date Signed: _____/_____/_____