

**IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY ANNUITY TRUST**

1470 Worldwide Place • Vandalia, Ohio 45377-1156

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 your Annuity 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 is 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: \_\_\_\_/\_\_\_\_/\_\_\_\_