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DISABILITY PENSION EXAMINATION REPORT
SUBMIT ORIGINAL – COPIES NOT ACCEPTED
(To Be Completed By Disabling Physician)

Iron Workers' Name	Date of Birth	Social Security No.

Iron Worker's Address (Street, City, State, Zip)

Diagnosis and Concurrent Conditions

Patient History and Report of Services

Dates of Service	Place of Service(s)	Description of Surgical or Medical Services

Do you consider this patient to be Totally and Permanently Disabled by the following definition: *Patient 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*** *Such disability will be permanent and continuous for the remainder of his/her life*:

❑ **Yes** ❑ **No**

If yes, please provide the date his/her total disability began: ______/_____/______

Is Medical Treatment required at the present time? ❑ Yes ❑ No

I recommend re-examination in approximately (days/weeks/months):________________________________

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

Physician's Printed Name	Degree (Must be an M.D. or D.O.)
Physician's Address (Street, City, State, Zip)	**Physician's Phone Number**
Physician's Signature	**Date Signed:**