PHYSICIAN'S MEDICAL REPORT
(To be completed by Applicant's Physician)

TO: BOARD OF TRUSTEES
MICHIANA AREA ELECTRICAL WORKERS' PENSION FUND

Re: Name: ______________________ Social Security No: ______________________

Address: ____

____

Diagnosis: ____

Concurrent Conditions: ____

When did these symptoms first appear or accident/injury happen? Date: ______________________

Is the disability due to accident/injury or sickness arising out of the patient's employment? Yes No

When did the patient first consult you for this condition? Date: ______________________

How long have you know this patient? Since ______________________

When did you last examine this patient for this condition? Date: ______________________

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise? Yes No

Was the disability self-inflicted? Yes No

Is this patient totally unable to engage in his/her regular occupation or employment for renumeration or profit as the result of this disability? Yes No

As of what date did this occur? Date:

Do you consider this disability to be permanent? Yes No

If no, what is the probable future duration?

(PLEASE COMPLETE BOTH SIDES OF THIS REPORT)

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Is this patient totally unable to engage in his/her regular occupation or employment at the electrical trade as the result of this disability? Yes No

As of what date did this occur?

Do you consider this disability to be permanent? Yes No

What employment can this patient engage in?______________________________________

What employment is this patient restricted from?____________________________________

____

Physician’s Signature:____

Please type or print the following:

Physician’s Name:____

Address:____

____

Telephone Number:____

BOARD OF TRUSTEES
MICLIIANA AREA ELECTRICAL WORKERS' PENSION FUND
6525 Centurion Drive
Lansing, MI 48917-9275

(PLEASE COMPLETE BOTH SIDES OF THIS REPORT)

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