INDIANA LABORERS PENSION FUND

PHYSICIAN'S REPORT

To the Board of Trustees,

Regarding: Name _____ Soc. Sec. No. _____

PLEASE MAKE YOUR REPORT COMPLETE ENOUGH TO ENABLE A REVIEWING PHYSICIAN TO DETERMINE THE NATURE AND SEVERITY OF IMPAIRMENT.

1. I examined this applicant on _____ at _____
month day year

PHYSICAL MEASUREMENTS Give applicant's height and weight at last visit.	inches_____ lbs. _____
HISTORY (a) When did present illness or injury occur?. . . . . . (b) Date applicant became unable to work?. . . . . . (c) Is there a previous history of this illness?. . . . . . If "yes," desribe.	
PRESENT CONDITION (ALL MAJOR IMPAIRMENTS) (a) Subjective symptoms . . . . . . (b) Objective findings . . . . . . Give report of X-rays, ECG's, laboratory or diagnostic tests, with dates. Use separate sheet if neccesary. (c) Is applicant . . . . . Ambulatory? ☐ Bed confined? ☐ House confined? ☐ Hospital confined? ☐	
DIAGNOSIS	
DIAGNOSIS (a) Is condition static? . . . . . . (b) If not, what optimum improvement can be expected, if any?. . . . . . (c) When? 6 Months ☐ 1 Year ☐ Indefinite ☐ (d) Desribe specific restrictions, if any, on Patient's activity.	

If disability is due to CARDIAC, RESPIRATORY, ARTHRITIC, NEUROLOGICAL CONDITIONS
please amplify below with latest findings and dates.

CARDIAC	(a) Precise diagnosis including functional and therapeutic classification, American Heart Ass'n . . . . . . (b) Describe heart size and contour. . . . . . (c) Blood pressure . . . . . . (d) What kind and amount of activity or stress Results in (1) Dyspnea (2) Angina (e) Edema - (Give location).	
RESPIRATORY	(a) Acute attacks . . . . . Frequency, duration and severity . . . . . . (b) Deformity of chest wall . . . . . . (c) Emphysema . . . . . . (d) Vital capacity in cc's . . . . . . (e) What kind and amount of activity results in dyspnea . . . . . . (f) If TB, give National TB Association Clasification	
ARTHRITIS	(a) Physical Findings -- Give specific findings for all joints involved; describe deformities, tissue and bone destruction, range of motion. . . . . . (b) X-ray report	
NEUROLOGICAL	Describe any of the following conditions that are present, indicating severity, distribution, and residual function in affected parts. . . . . Atrophy, Tremors, Paralysis, Gait, Hemiplegia, Reflexes, Impaired speech, Mental disturbances Lab findings: Cerebrospinal fluid (Wassermann, protein, cell count, etc.) X-ray findings, EEG's, other.	(Additional Narrative Report is Desirable)

Based on my examination and conversation with the applicant, it is my opinion that the disability:
(Circle words in brackets that apply)

a.	(Was)	(Was not)	contracted, suffered, or incurred while the employee was engaged in, or the result of having engaged in a criminal enterprise, or
b.	(Did)	(Did not)	result from addiction to narcotics, or
c.	(Was)	(Was not)	self-inflicted, or
d.	(Did)	(Did not)	result from service in the Armed Forces of the United States of America.

I hereby certify that: (Please initial only the box that best describes the applicant)

☐ I am of the opinion this applicant is totally and permanently disabled. The disability is expected to be permanent and continuous for the rest of the applicant's life.

☐ I am of the opinion this applicant can engage in employment for profit or pay, but not in the construction industry.

☐ I am of the opinion this applicant can engage in employment for profit or pay which is considered inconsistent with the definitions of Total & Permanent and/or Occupational Disability.

Date _____ By: _____
Physician's Signature

_____ Address: _____
Printed Physician's Name

_____

01/10