

**IRON WORKERS DISTRICT COUNCIL  
OF SOUTHERN OHIO & VICINITY ANNUITY TRUST**  
Main P.O. Box 398 Dayton, Ohio 45401  
Toll Free: (800) 331-4277

**DISABILITY ANNUITY EXAMINATION REPORT**

Please print or type. This form **MUST** be returned with your annuity application!

Patient's Name \_\_\_\_\_  
Last Name First Name middle initial

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_  
City State Zip

Social Security # \_\_\_\_\_ Union Book # \_\_\_\_\_ Local \_\_\_\_\_

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 presumably 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 if based on the following:

Diagnosis \_\_\_\_\_  
\_\_\_\_\_

History \_\_\_\_\_  
\_\_\_\_\_

Date Total Disability Started \_\_\_\_\_

Medical Treatment is not required at the present time. I recommend re-examination in approximately \_\_\_\_\_

Date member first consulted you for this condition \_\_\_\_\_

Dates of treatments and/or examinations within the past 12 months \_\_\_\_\_  
\_\_\_\_\_

Remarks (use reverse side if more space is needed) \_\_\_\_\_  
\_\_\_\_\_

Doctor's Name \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Degree \_\_\_\_\_

Date Signed \_\_\_\_\_

Only an MD or a DO will be accepted