

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

Main P.O. Box 398 Dayton, Ohio 45401

Toll Free: (800) 331-4277

DISABILITY PENSION EXAMINATION REPORT

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

Patient's Name _____

Street Address _____

City, State, Zip Code _____

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 is 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 _____

Only an MD or a DO will be accepted

Date Signed _____