Alaska Plumbing & Pipefitting Industry Pension Trust Fund

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

FOR THE PARTICIPANT TO COMPLETE: I, ________________________________, hereby authorize the undersigned physician to release the following requested information to the Alaska Plumbing and Pipefitting Industry Pension Trust Fund. I also authorize the undersigned physician to release any additional medical information to the Pension Trust Fund that he/she believes may be of assistance to me in my claim for disability retirement benefits.

________________________________ ________________________________
Signature Of Participant Date Signed

Dear Doctor: We need your help. Please complete this form. Promptness in completing this form and use of layman's language will greatly assist us in making a determination of your patient's eligibility for disability retirement benefits.

Patient's Name: ________________________________ Age: ________

GENERAL HISTORY:

When did present illness begin, or injury occur: ________________________

When did patient first consult you for this condition: ________________________

PRESENT CONDITION:

Past History of symptoms and complaints:

____

____

____

Objective findings: (Give report of X-rays, E.K.G.s and describe in full, nature of surgical or obstetrical procedure, if any, and chart/clinical notes)

____

____

____

Do you know if any other physicians are/have been treating the patient for the same condition? If yes, please provide name, address and telephone number.

____ (   )__________
Name Address Telephone Number

DIAGNOSIS:

Nature of sickness or injury, describe complications, if any:

____

____

____

TREATMENT SCHEDULE:

CONTINUED ON REVERSE

Date of first visit: ____

Date of last visit: ____

Frequency of visits: ____

Date(s) of hospitalization, if any: ___________________________________

____

Name of Hospital City State Zip

When did you last examine this patient: ______________________________

PROGRESS TO DATE (Check One) CURRENT STATUS (Check One)

PROGRESS TO DATE		CURRENT STATUS	
Recovered	________	Ambulatory	________
Improved	________	Bed Confined	________
Unimproved	________	House Confined	________
Retrogressed	________	Hospital Confined	________

PROGNOSIS & COMMENTS (Please type or print in layman's language)

____

____

____

In your opinion, is the patient totally disabled? _______ Yes _______ No
(For purposes of this plan, total and permanent disability is defined as disability by bodily injury, disease, or mental disorder, which permanently prevents the patient from working for an Employer in the plumbing and pipefitting industry or engaging in any other regular employment for an Employer or engaging in any other substantially gainful occupation, which he/she would be expected to be able to perform in light of his/her training, experience, and abilities.)

How long was or will patient be totally disabled?

From ____________________ through ____________________

____

_________________________________ ( )_________________________

Physician's Printed Name And Credentials Telephone Number

____

Name Of Clinic Or Facility, If Applicable

____

Street Address City State Zip

_________________________________ _________________________

Signature of Attending Physician Date Signed

(No Facsimile Stamp, Please)