Western Metal Industry Pension Fund

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Administered by
Welfare & Pension Administration Service, Inc.

PHYSICIAN'S REPORT ON DISABILITY APPLICATION

A. History and Diagnosis

1. Name of Patient _____
2. Age_____ 3. Height_____ft._____in. 4. Weight_____lbs.
5. Blood pressure_____/_____*(resting)* 6. Pulse_____/min. *(resting)*
7. Respirations_____/minute *(resting)*
8. Clinic Diagnosis: *(Please list all contributing conditions)*

_____

_____

9. Date disabling condition treated by any physician _____
10. Date you first treated for disabling condition _____
11. Date you last treated for disabling condition _____
12. Frequency of treatment: *(please check one)*
    Monthly ☐ Weekly ☐ More Often ☐
13. Nature of Symptoms: *(please check one)*
    Progressive ☐ Stationary ☐ Improving ☐
14. Nature of confinement: *(please check one)*
    Bed ☐ Home ☐ Hospital ☐ Not Confined ☐
15. Can this disabling condition be surgically corrected?
    Yes ☐ No ☐
    If yes:
    a. Prognosis for successful surgery: *(please check one)*
       Good ☐ Fair – 50/50 ☐ Poor ☐
    b. Has patient consulted with a surgeon about surgical correction?
       Yes ☐ No ☐

B. Nature of Disability

1. Extent: *(please check 'a' or 'b', below)*
   a. _____Total. *(Disability, which renders patient incapable of continuing employment in any gainful occupation for which substantial retraining would not be required.)*
   b. _____Partial. *(Disability, which renders patient incapable of continuing employment in occupation of present job description.)*

(Please complete both sides)

2. Duration: *(please check 'a' or 'b', below)*
   a. Permanent. *(Disability expected to last the remainder of the patient's lifetime.)*
   b. Temporary. *(Disability expected to last at least two years from onset but not for the remainder of the patient's lifetime.)*

3. Continuity:
   Has disability been continuous from onset? Yes ☐ No ☐
   If "No", please state period of which patient was not disabled:
   From_____to_____

4. Date of disability establishment or onset _____. If cause of disability is degenerative or chronic, as opposed to accidental or acute, please state change or stage of condition, which resulted in your determination of the above date for disability onset.

   _____

   _____

   _____

5. This disabled patient is a *(check one)* Good ☐ Fair ☐ Poor ☐ candidate for rehabilitation.

C. Miscellaneous Considerations

1. This disability *(check one)* does ☐ does not ☐ result from a self-inflicted injury. If so, please explain:

   _____

2. Additional Comments: _____

   _____

   _____

_____ _____ _____
Physician's Signature Degree / Specialty Date

Physician Name and Address: *(print or type)*

Name: _____

Street: _____

City: _____

State:_____ Zip Code: _____

Telephone:_____ Fax: _____