Western Metal Industry Pension Fund

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124 Rj qpg'*428+'886/9522"qt '*: 22+'648/9354'ÉHcz '*428+'8; 7/2; : 6'É'Y gdukg<'y y y 0y o kr gpukqp0qti

Administered by

Welfare & Pension Administration Service, Inc.

PHYSICIAN'S REPORT ON DISABILITY APPLICATION

A. History and Diagnosis

- Name of Patient _____
 Height _____ ft. 4. Weight in. lbs.
- Blood pressure / (resting)
 Respirations /minute (resting) 6. Pulse /min. (resting)
- 8. Clinic Diagnosis: (Please list <u>all</u> 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 \Box Weekly \Box More Often \Box
- 13. Nature of Symptoms: (please check one) Progressive \Box Stationary \Box Improving \Box
- 14. Nature of confinement: (please check one) Home Hospital Not Confined Bed 🗆
- 15. Can this disabling condition be surgically corrected? Yes 🗆 No 🗆

If yes:

- a. Prognosis for successful surgery: (please check one) Good \Box Fair – 50/50 \Box Poor \Box
- 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	1)
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- 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 <u>not</u> for the remainder of the patient's lifetime.)
- Continuity: Has disability been continuous from onset? Yes □ No □ If "No", please state period of which patient was <u>not</u> 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 \Box Fair \Box Poor \Box candidate for rehabilitation.

C. Miscellaneous Considerations

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

Physician's Signature	Degree / Specialty	Date	-
Physician Name and Addres	ss: (print or type)		
Name:		_	
Street:		_	
City:		_	
State:	Zip Code:	_	
Telephone:	Fax:	_	