

DISABILITY MEDICAL REPORT

Patient Name _____ Date of Birth _____ Reg# _____

Patient's Authorization to Release Information

I hereby authorize the release of information from and concerning my medical records to the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan Trustees, their agents, their consulting physicians and my ILWU Local.

Signature of Patient

Date

To be completed by the Participant's Attending Physician.

Is this for claiming **pension credit only**? YES NO – If YES, please complete questions 1 and 2 only.

Is this for a **Disability Retirement application**? YES NO – If YES, please complete questions 1 through 6.

1. Date of injury/onset of illness? _____
2. Is the patient totally & permanently disabled for regular work in the Longshore / Watchman Industry? YES NO
If YES, enter the date the patient became totally and permanently disabled for their regular work? _____
3. On what date did you reach this conclusion? _____
4. Is the disability wholly attributable to an industrial (on-the-job) injury? YES NO
5. Is treatment continuing? YES NO If YES, date the patient was last seen: _____
6. In the space below, enter summary of medical condition, diagnoses, and physiological limitations or impairment
OR → Check here if attaching documentation providing the Plan's *Reviewing Doctor* with sufficient information to make an independent decision (narrative, medical summary, office notes, lab &/or test results, etc.).

Signature of Attending Physician

Date

Print Physician Name

Telephone #

Address, City, State, Zip

To be completed by Pension Plan Reviewing Doctor

- I concur with the conclusions of the examining doctor.
- I do not concur with the conclusions of the examining doctor.

Signature of Plan Reviewing Doctor

Date