PHYSICIAN'S MEDICAL REPORT
(To be completed by Applicant's Physician)

TO: THE BOARD OF TRUSTEES OF THE MILLWRIGHTS LOCAL 1102 SUPPLEMENTAL PENSION FUND

RE: Name: _____Social Security Number:_____

Address: _____City:_____State:_____Zip Code:_____

Diagnosis: _____

Concurrent Conditions: _____

When did these symptoms first appear or accident/injury happen? Date: _____

Is the disability due to accident/injury or sickness arising out of the patient's employment? □ Yes □ No

When did the patient first consult you for this condition? Date: _____

How long have you know this patient? Since _____

When did you last examine this patient for this condition? Date: _____

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise? □ Yes □ No

Was the disability self-inflicted? □ Yes □ No

Is this patient totally unable to engage in his/her regular occupation or employment at the Millwright Trade as the result of this disability? □ Yes □ No

As of what date did this occur? Date: _____

Do you consider this disability to be permanent? □ Yes □ No

If no, what is the probable future duration? _____

_____

What employment can this patient engage in? _____

_____

What employment is this patient restricted from? _____

_____

_____

Physician's Signature: _____

Please type or print the following:

Physician's Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____
(Area Code)

Date_____

MILLWRIGHTS LOCAL 1102 SUPPLEMENTAL PENSION FUND
6525 Centurion Drive
Lansing, MI 48917-9275

(517) 321-7502 • FAX (517) 321-7508
TOLL FREE (888) 228-6700