Teachers' Retirement System of Louisiana
8401 United Plaza Blvd, Ste 300 • Baton Rouge, LA 70809-7017
PO Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446 • Fax: (225) 925-6366
Toll free (outside the Baton Rouge area): 1-877-ASK-TRSL (877-275-8775)
www.TRSL.org • *web.master@trsl.org*

Form 12B (05/05)
08-12B

Member Statement of Disabling Condition

Print in ink or type all entries except signatures. Describe, in detail, the nature of your disabling condition and how the condition affects current job performance. If additional space is needed, you may attach additional sheets. **This statement must be submitted to the Teachers' Retirement System of Louisiana (TRSL) with the *Application for Disability Retirement* (Form 12).** Both sides of this form must be completed.

Section 1 — Member Information

Name: Last, first, MI, suffix (Jr., III, etc.)

Social Security number

Title of position

Section 2 — Member Description of Condition

1. When did your disability begin?

_____ / _____ (approximate date is acceptable)
mm-yyyy

2. Describe the nature of your disabling condition:

3. Describe your job duties and how your disabling condition affects your ability to perform your job:

I understand that my application will not be submitted to the State Medical Disability Board until all required information, including copies of all medical records pertinent to my disabling condition, is received from all physicians listed on the reverse side of this form.

Member's signature (do not print or type) ▶

Date signed (mm / dd / yyyy)

Complete information on the reverse side

Member's Social Security number

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4. Reports regarding your disabling condition will be submitted by the following physicians (if additional space is needed, you may attach additional sheets):

Name of physician	Daytime telephone ( )
Street / P.O. Box	Area of specialty
City, state, zip	

Name of physician	Daytime telephone ( )
Street / P.O. Box	Area of specialty
City, state, zip	

Name of physician	Daytime telephone ( )
Street / P.O. Box	Area of specialty
City, state, zip	

Name of physician	Daytime telephone ( )
Street / P.O. Box	Area of specialty
City, state, zip	

Name of physician	Daytime telephone ( )
Street / P.O. Box	Area of specialty
City, state, zip	

5. Mark the major area of specialty of the physician you consult for your disability. This will determine the State Medical Disability Board physician that will review your medical records. If you are approved for disability retirement, it will also determine the type of physician that you will consult for your periodic re-exams.

MARK ONLY ONE BOX.

- ☐ Cardiology
- ☐ Internal Medicine
- ☐ Neurology
- ☐ Oncology
- ☐ Orthopedics
- ☐ Psychiatry
- ☐ Other (Specify: _____)