# Physician Report of Disabling Condition
(Form 12C)

08-12C
*rev. 01/21*

| HOW TO SUBMIT: | DROP OFF or MAIL IN | EMAIL | FAX |
|---|---|---|---|
| | 8401 United Plaza Blvd, Ste 300<br>Baton Rouge LA 70809 | *web.master@trsl.org* | (225) 925-6366 |

**Print in ink or type all entries except signatures.** It is the responsibility of the applicant to complete Sections 1 and 2 and to forward to the physician/health care provider for completion of Section 3.

## Section 1 - Applicant's information

| Name: Last, first, MI, suffix (Jr., III, etc.) | | Applicant's Social Security number (###-##-####) |
|---|---|---|
| Street address / PO box | | City, state, zip |
| Daytime telephone (*include area code*) | Evening telephone (*include area code*) | Email address |
| (*If applicant is **NOT** a member of TRSL*) Member name: Last, first, MI, suffix (Jr., III, etc.) | | Member Social Security number (###-##-####) |

## Section 2 - Applicant authorization for release of medical records

I hereby authorize my physician, whose name and address are listed below, to release all medical information and records relevant to my disabling condition directly to the Teachers' Retirement System of Louisiana.

| Name of physician | |
|---|---|
| Street address / PO box | City, state, zip |
| Applicant's signature (DO NO PRINT OR TYPE)<br>▶ | Date signed (*mm/dd/yyyy*) |

## Section 3 - Physician's report of disabling condition

It is necessary for the physician to provide pertinent and factual information needed to support both the diagnosis and prognosis of this patient's disabling condition. Objective clinical finding and laboratory evidence of the disabling condition must be of sufficient magnitude to justify this patient's claim of inability to continue performing his or her current job-related duties.

**TRSL requires the submission of all medical records relating to the disabling condition.** Copies of all medical records must accompany this report when submitted to TRSL. If you choose to dictate your medical report, please include the information outlined below. *Incomplete or inadequate information may result in a processing delay or denial of claim.*

This patient has been under my professional care since ________________________________ (*mm/dd/yyyy*).

Date last seen: ________________________________ (*mm/dd/yyyy*)

Have you referred this patient to another physician? ☐ Yes ☐ No

If yes, please provide the following information:

| Name of physician | Daytime telephone (*include area code*) |
|---|---|
| Street / PO box | City, state. zip |

Comments:

***COMPLETE & SIGN REVERSE SIDE***

Member's Social Security number

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## Section 3 - Physician's report of disabling condition (*cont'd*)

1. History of present injuries, infirmities, diseases, and disabilities:

2. Social history:

3. Review of system:

4. Vital signs: Height ____________ Weight ____________ Pulse rate ____________

5. Physical examination:

6. Neuropsychiatric examination:

7. Diagnosis and DSM/ICD code(s) — *include results of tests that document this diagnosis*:

8. Treatment and response:

9. Prognosis:

What are the patient's current functional abilities in the following areas in hours (based on an 8-hour day)

| | | | |
|---|---|---|---|
| Sitting | _______ | ☐ Continuously | ☐ With Rests |
| Standing | _______ | ☐ Continuously | ☐ With Rests |
| Walking | _______ | ☐ Continuously | ☐ With Rests |

Lifting ☐ 1-10 lbs ☐ 11-25 lbs ☐ 26-50 lbs ☐ Over 50 lbs

Cardiac functional capacity (if applicable). Rate based on American Heart Association rules:

☐ Class 1 (no limitation) ☐ Class 3 (marked limitation)
☐ Class 2 (slight limitation) ☐ Class 4 (complete limitation)

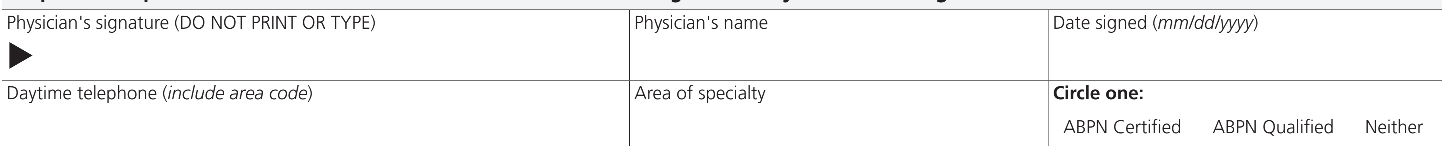
| **Activities:** | **Never** | **Occasionally** | **Frequently** | **No restriction** |
|---|---|---|---|---|
| Bending | ☐ | ☐ | ☐ | ☐ |
| Stooping | ☐ | ☐ | ☐ | ☐ |
| Climbing | ☐ | ☐ | ☐ | ☐ |
| Squatting | ☐ | ☐ | ☐ | ☐ |
| Reach above shoulder | ☐ | ☐ | ☐ | ☐ |
| Driving | ☐ | ☐ | ☐ | ☐ |

### *Additional psychiatric questions, if applicable*

10. Places and dates of any psychiatric hospitalizations:

11. Mental status when last seen:

**Copies of all pertinent medical records must be attached, including laboratory and other diagnostic test results.**



| Physician's signature (DO NOT PRINT OR TYPE) ▶ | Physician's name | Date signed (*mm/dd/yyyy*) |
|---|---|---|
| Daytime telephone (*include area code*) | Area of specialty | **Circle one:** ABPN Certified ABPN Qualified Neither |