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 12C (08/03)
08-12C

Not for use by psychiatrist

Physician Report of Disabling Condition

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 for completion of Section 3.

Section 1 — Applicant Information

Applicant's name: Last, first, MI, suffix (Jr., III, etc.)

Applicant's Social Security number

Street / P.O. Box

City, state, zip

Daytime telephone ( )

Evening telephone ( )

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 (TRSL).

Name of physician

Street / P.O. Box

City, state, zip

Applicant's signature (Do not print or type) ▶

Date signed (mm-dd-yyyy)

Section 3 — Physician's Report of Patient's 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 findings 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. **The Teachers' Retirement System of Louisiana (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.

1. This patient has been under my professional care since _____ / _____ / _____.
   Month Day Year

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

3. Social history:

4. Review of system:

5. Vital signs: Height_____ Weight_____ Pulse rate_____

Complete reverse side

6. Physical examination:

7. Neuropsychiatric examination:

8. Diagnosis (include results of tests that document this diagnosis):

9. Treatment and response:

10. Prognosis:

11. Have you referred this patient to another physician? Yes ☐ No ☐
If yes, provide the following information:

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

12. Comments:

Copies of all pertinent medical records must be attached, including laboratory and other diagnostic test results. (X-rays, if needed by the medical board, will be requested later.)

Physician's signature (Do not stamp, print, or type.) ▶	Date signed (mm-dd-yyyy)
Area of specialty	Daytime telephone ( )