



Teachers' Retirement System of Louisiana
 8401 United Plaza Blvd, Ste 300 • Baton Rouge, LA 70809-7017
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 Toll free (outside the Baton Rouge area): 1-877-ASK-TRSL (877-275-8775)
 www.TRSL.org • web.master@trsl.org

Form 12C-P (08/03)

08-12CP

**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		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>											
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 — Psychiatrist's Report (Incomplete or inadequate information may result in processing delay or denial of claim)

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 _____ / _____ / _____;
 date last seen _____ / _____ / _____.
 Month Day Year

2. History of present condition (date of onset, symptoms, cause(s), treatment, and response):

Applicant's Social Security number

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3. Places and dates of any psychiatric hospitalizations:

4. Social and biographical history:

5. Mental status when last seen:

6. Diagnosis:

- Axis I
- Axis II
- Axis III


7. 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	

8. 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)
Number of years residency training _____, Locale _____ Circle one: ABPN Certified ABPN Qualified Neither	Daytime telephone ()