Teachers' Retirement System of Louisiana
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P.O. Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446 • Fax: (225) 925-4779
Toll free (outside the Baton Rouge area): 1-877-ASK-TRSL (877-275-8775)
www.TRSL.org • *web.master@trsl.org*

Form 12D (08/10)

08-12D

Physician Annual Report of Disabling Condition — *FOR RETIREES ONLY*

Print in ink or type all entries except signatures. It is the responsibility of the retiree to complete Sections 1 and 2 and to forward to the physician for completion of Section 3.

Section 1 — Retiree Information

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

Retiree's Social Security number

Street / P.O. Box

City, state, zip

Daytime telephone ( )

Evening telephone ( )

Section 2 — Retiree 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 __________ / ___________ / __________.
   (mm / dd / yyyy)

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

3. Social history:

4. Review of system:

5. Vital signs: Height_______________ Weight_______________ Pulse rate_______________
   Blood pressure, both arms: Right_______________ Left_______________

Complete reverse side

Retiree's Social Security number

6. Physical examination:

7. Neuropsychiatric examination:

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

9. Treatment and response:

10. Prognosis:

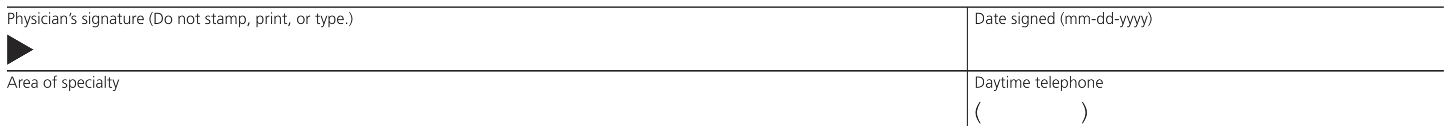
11. Have you referred this patient to another physician? Yes ☐ No ☐
If yes, provide the following information:

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

12A. In your opinion, is this patient able to return to full-time work without any restrictions in the same area of work as when previously employed? Yes ☐ No ☐

12B. In your opinion, is this patient's condition terminal or are chances of recovery highly improbable? Yes ☐ No ☐

13. Comments:



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