



# 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 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 <b>NOT</b> 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 NOT PRINT OR TYPE)	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)	Activities:	Never	Occasionally	Frequently	No restriction
Sitting _____ <input type="checkbox"/> Continuously <input type="checkbox"/> With Rests	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing _____ <input type="checkbox"/> Continuously <input type="checkbox"/> With Rests	Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking _____ <input type="checkbox"/> Continuously <input type="checkbox"/> With Rests	Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting <input type="checkbox"/> 1-10 lbs <input type="checkbox"/> 11-25 lbs <input type="checkbox"/> 26-50 lbs <input type="checkbox"/> Over 50 lbs	Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac functional capacity (if applicable). Rate based on American Heart Association rules:	Reach above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Class 1 (no limitation) <input type="checkbox"/> Class 3 (marked limitation)	Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Class 2 (slight limitation) <input type="checkbox"/> Class 4 (complete limitation)					

**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	<b>Circle one:</b> ABPN Certified    ABPN Qualified    Neither