TRSL
Teachers' Retirement System of Louisiana

Physician Annual Report of Disabling Condition

FOR RETIREES ONLY (Form 12D)

08-12D
rev. 07/21

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 retiree to complete Section 1 and to forward to the physician for completion of Sections 2 and 3.

Section 1 - Retiree information

Name: Last, first, MI, suffix (Jr., III, etc.)	Your Social Security number (*###-##-####*)
Street address / PO box	City, state, zip
Daytime telephone (*include area code*)	Email address

Section 2 - 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. If the medical report will be dictated, please include the information outlined below.

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

2. Review of system:

3. Social history:

4. **Vital signs:** Height _____ Weight _____ Pulse rate _____ Blood pressure _____

5. Physical examination:

6. Neuropsychiatric examination:

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

See reverse to complete and sign application. →

Retiree's Social Security number

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Section 2 - Physician's Report of Patient's Disabling Condition (*cont'd*)

8. Treatment and response:

9. Prognosis:

10A. In your opinion, is this patient currently able to return to full-time work without any restrictions in the same area of work as when previously employed?

☐ Yes ☐ No

10B. In your opinion, is this patient's condition terminal or are chances of recovery highly improbable?

☐ Yes ☐ No

10C. In your opinion, will this patient ever be able to return to full-time work without any restrictions in the same area of work as when previously employed?

☐ Yes, but not at this time

☐ No, has a total and permanent disability

☐ Cannot be determined at this time

Section 3 - Physician signature (*The section below must be signed by a licensed physician*.)

Physician name	License number
Physician signature ▶	Date signed (*mm/dd/yyyy*)
Physician's area of specialty	Physician's daytime telephone (*include area code*)