TRSL Teachers' Retirement System of Louisiana

# Statement of Child's Permanent Disabling Condition (Form 12PDMC)

**08-12PDMC**
*rev. 01/21*

| HOW TO SUBMIT: | DROP OFF or MAIL IN | EMAIL | FAX |
|---|---|---|---|
| | 8401 United Plaza Blvd, Ste 300<br>Baton Rouge LA 70809 | *web.master@trsl.org* | (225) 925-6366 |

**Print or type all entries below, except signatures.** Describe, in detail, the nature of the child's disabling condition. If additional space is needed, please attach additional sheets. **This statement must be submitted to TRSL with the *Physician's Statement of Disabling Condition* (Form 12C).**

## **Section 1** - Member and child information

| Member name: Last, first, MI, suffix (Jr., III, etc.) | Member Social Security number (###-##-####) |
|---|---|
| Child's name: Last, first, MI, suffix (Jr., III, etc.) | Child's Social Security number (###-##-####) |

## **Section 2** - Description of child's condition

1. When did child's disability begin (*mm/dd/yyyy - approximate date OK*)

2. Describe the nature of child's disabling condition:

3. Reports regarding child's disabling condition will be submitted by the following physicians. (If additional space needed, attach additional sheets.):

| Name of physician<br>**1)** | | Area of specialty |
|---|---|---|
| Street / PO box | City, state, zip | Daytime phone number (include area code) |
| Name of physician<br>**2)** | | Area of specialty |
| Street / PO box | City, state, zip | Daytime phone number (include area code) |

4. Mark the major area of specialty of the physician the child consults for his or her disability. This will determine the State Medical Disability Board physician that will review the medical records.

☐ Cardiology ☐ Neurology ☐ Orthopedics ☐ Other (specify): _____

☐ Internal Medicine ☐ Oncology ☐ Psychiatry

## **Section 3** - Signature

I understand that child's file will not be submitted to the State Medical Disability Board until all required information, including copies of all medical records pertinent to the disabling condition, is received from all physicians listed on this form.

| Signature of child 18 years or older with legal capacity/parent/tutor/curator/trustee (DO NOT PRINT OR TYPE) ▶ | Date signed (*mm/dd/yyyy*) |
|---|---|