

**PHYSICIAN'S MEDICAL REPORT**  
(To be completed by Applicant's Physician)

**TO: THE BOARD OF TRUSTEES OF THE MICHIGAN CARPENTERS' PENSION FUND**

RE:	Name: _____	Social Security Number: _____
	Address: _____	City: _____ State: _____ Zip Code: _____

Diagnosis: \_\_\_\_\_

Concurrent Conditions: \_\_\_\_\_

When did these symptoms first appear or accident/injury happen? Date: \_\_\_\_\_

Is the disability due to accident/injury or sickness arising out of the patient's employment?    Yes            No

When did the patient first consult you for this condition? Date: \_\_\_\_\_

How long have you know this patient? Since \_\_\_\_\_

When did you last examine this patient for this condition? Date: \_\_\_\_\_

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise?	Yes	No
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Was the disability self-inflicted?	Yes	No
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Is this patient totally unable to engage in his/her regular occupation or employment for remuneration or profit as the result of this disability?	Yes	No
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As of what date did this occur? Date: \_\_\_\_\_

Do you consider this disability to be permanent?	Yes	No
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If no, what is the probable future duration? \_\_\_\_\_

\_\_\_\_\_

Is this patient totally unable to engage in his/her regular occupation or employment at the carpentry trade as the result of this disability?

Yes

No

As of what date did this occur? \_\_\_\_\_

Do you consider this disability to be permanent?

Yes

No

If no, what is the probable future duration? \_\_\_\_\_

What employment can this patient engage in? \_\_\_\_\_

What employment is this patient restricted from? \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Please type or print the following:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_  
(Area Code)

**MICHIGAN CARPENTERS' PENSION FUND  
6525 Centurion Drive  
Lansing, MI 48917**

**(PLEASE COMPLETE BOTH SIDES OF THIS REPORT)**