Form 6

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The Teachers' Pensions Act

Name _____ Date of Birth or Age _____

Present Address _____ No. _____ Street _____ City _____

(If space for any answer is insufficient use section 9 on reverse side)

1. HISTORY (a) When did illness begin, or injury occur? (b) On what date did teacher have to cease work? (c) Is there a previous history of this illness?	 Month Day Year Month Day Year ❑ No ❑ Yes (give details) _____ _____
2. CONDITION CAUSING DISABILITY (a) Subjective symptoms . . . . . . (b) Objective findings . . . . . . (Please give report of X-rays, EKGs or any other special tests) (c) Is or was teacher (house confined? . . . . . . (bed confined? . . . . . . (hospital confined?	 ❑ No ❑ Yes From To ❑ No ❑ Yes From To ❑ No ❑ Yes From To
3. DIAGNOSIS	
4. TREATMENT (a) Date of first visit . . . . . . (b) Date of last visit . . . . . . (c) Frequency of visits	 Month Day Year Month Day Year
5. PROGRESS	❑ Recovered ❑ Unimproved ❑ Improved ❑ Retrogressed
6. DURATION OF TOTAL DISABILITY (a) Is teacher now totally disabled and unable to do any work? . . . . . . (b) Is teacher expected to return to work? . . . . . . (c) If yes, when do you think the teacher will be able to resume any work?	 ❑ No ❑ Yes ❑ No ❑ Yes Approximate date Month _____ Day _____ Year _____

Form 6 (continued)

7. If disability involves a mental condition, is the teacher competent to manage his or her financial affairs?	❑ No ❑ Yes

8. THIS SECTION APPLIES ONLY IF THE DISABILITY IS DUE TO CARDIAC CONDITION, HEARING DEFICIENCY OR VISUAL IMPAIRMENT.

(a) CARDIAC (1) Functional capacity (American Heart Ass'n) Class 1 (No limitation) . . . . . . Class 2 (Slight limitation) . . . . . . Class 3 (Marked limitation) . . . . . . Class 4 (Complete limitation)	 _____ _____ _____ _____
(b) HEARING DEFICIENCY (1) Is teacher totally deaf? . . . . . . (2) If not totally deaf, what was hearing level last observed? . . . . . . (3) Can hearing be improved by treatment, operation or mechanical aids?	❑ No ❑ Yes _____ ❑ No ❑ Yes (indicate extent) _____ _____
(c) VISUAL IMPAIRMENT (1) Is teacher totally blind? (2) If not totally blind, what was vision at last observation? (Snellen Notation) With Glasses . . . . . . Without Glasses . . . . . . (3) What is the extent of any gross visual field defect? . . . . . . (4) Can vision be improved by treatment, operation or lenses?	❑ No ❑ Yes O.D. O.S. Date O.D. O.S. Date _____ ❑ No ❑ Yes (indicate extent) _____ _____

9. REMARKS:

Date_____ Signature _____ M.D.

Address _____

10. OFFICE USE