IBEW 861 PENSION FUND

BENEFIT RESOURCES, INC.

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HOUSTON, TEXAS 77017

TELEPHONE: (713) 643-9300 FAX: (866) 316-4794

PHYSICIAN'S CERTIFICATION OF MEDICAL CONDITION

(MUST MEET IBEW 861 ELIGIBILITY CRITERIA. PLEASE READ DISABILITY PROVISION BEFORE COMPLETING)

PATIENT'S NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip Code

SOCIAL SECURITY NUMBER: _____

My conclusions upon examination of the patient are as follows:

1. Diagnosis/Nature of Disability/ Illness: _____

   _____

   _____

2. Percentage of whole body disability: _____

3. a) Date permanent disability/illness started: _____

   b) Date first examined: _____

   c) Date most recently examined: _____

   d) Is medical treatment required at this time? _____

   e) Date of next anticipated treatment: _____

   f) Projected period of treatment: _____

4. Do you recommend surgery at this time?

   ☐ Yes ☐ No If yes, what procedure? _____

5. A) Is the patient able to perform the following physical activities?

If YES, please indicate any limitations the patient may have in performing the specific activities:

	NO	YES	Without Limitations	With Limitations (Please specify length of time, etc.)
Standing				
Standing w/arms overhead				
Sitting				
Lying down				
Walking				
Kneeling				
Climbing				
Squatting				
Bending				
Jumping				
Stooping				
Crawling				
Driving a vehicle				
Working at heights				
Pulling				
Pushing				
Lifting				
Carrying				
Hoisting				
Supervising other workers doing above activities				
Inspecting work performed by other workers				

B) Do you anticipate any improvement in the patient's physical limitations?

☐ Yes ☐ No Please explain: _____

_____

6. Please list all medications or treatments you have prescribed or recommended for this patient.

_____

_____

7. **Physician Must Check ✓ one:**

☐ I find the above named individual to be totally and permanently disabled by bodily injury, disease or illness so as to be prevented from engaging in any further employment, or self-employment as an electrical worker, and find that such disability will be permanent and continuous during the remainder of his life.

☐ I find the above named individual not to be totally and permanently disabled for the remainder of his life so as to prevent him from engaging in any further employment, or self-employment as an electrical worker.

_____ _____

Physician's Signature Physician's Name (Please print)

_____

Address City State Zip

_____

Phone Number

_____

Date