PHYSICIAN'S REPORT

To: Board of Trustees

Regarding: Name _____ SSN _____

1. I examined this applicant on _____ at _____
   Month Day Year

2. The nature of his/her disability is _____
   _____
   (Use reverse side, if necessary)

3. The disability commenced on or about _____
   Month Day Year

4. I consider the probable future duration of this disability to be _____
   _____

5. Based upon my examination and conversation with the applicant, it is my opinion that the disability:
   (mark out words in brackets that do not apply)

   a. (was) (was not) contracted, suffered or incurred while the employee was engaged in, or the result of his/her being engaged in a criminal enterprise; or
   b. (did) (did not) result from addiction to narcotics; or
   c. (was) (was not) self-inflicted; or
   d. (is) (is not) chronic alcoholism

   Based upon my examination and conversation with the application, and pursuant to the attached definitions of Industry-Related Disability and Total and Permanent Disability under the SMW Local No. 33 Cleveland District Pension Fund:

   - ☐ I am of the opinion that this applicant has a Total and Permanent Disability.
   - ☐ I am of the opinion that this applicant has an Industry-Related Disability.
   - ☐ I am of the opinion that this applicant is not disabled.

6. Signed on _____
   Month Day Year

   By: _____
   Physician's Signature

   _____
   Physician's Printed Name

   _____
   Address

   _____
   City State Zip

   _____
   Phone

**Please submit test results and other available evidence that led to your findings.