TIMBER OPERATORS COUNCIL, INC. – I.W.A. PENSION PLAN AND TRUST

PHYSICIAN'S DISABILITY STATEMENT

Patient's Name: _____ Social Security #: _____

This will certify that I have examined the above-named employee. The results of my examination are shown in the answers to the following questions:

Note: For the purpose of determining eligibility for the disability retirement benefits, the term 'disability' means inability to engage in any substantial, gainful activity by reason of a medically determinable impairment that may be expected to be of long, continued and indefinite duration. The employee cannot qualify for disability retirement benefits under the Plan if the disability is incurred in or results from any military or naval service.

1. Is the patient able to perform work at any occupation (other than casual)? _____

2. If not, what date has the patient been determined to be totally disabled? _____

3. Has the patient's disability been continuous? _____

4. In your opinion, will the patient recover sufficiently to resume work? _____

5. Is the patient's disability the result of service in the Armed Forces of any county, warfare, participation in any felony or intentional self-inflicted injury? _____

6. Please give a description of the patient's illness or injury: _____

_____

_____

7. Are there any additional comments you wish to add?_____

_____

_____

_____ _____

Physician's Signature Date

_____ (_____)_____

Physician's Address Phone Number

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