AMERICAN FEDERATION OF MUSICIANS AND EMPLOYERS' PENSION FUND
PO BOX 2673 NEW YORK, NEW YORK 10117-0262

DISABILITY PENSION APPLICATION
ATTENDING PHYSICIAN'S STATEMENT

The following section must be completed and signed by the Participant/patient.
Any fee for the completion of this form is the Participant's responsibility.

Name: Last First MI	Social Security No.
Home Address	Date of Birth [mm/dd/yy]
Musical Instrument(s) You Played	Your Pension ID Number

I hereby authorize my physician to release any information acquired in the course of my examination or treatment.

Signature of Participant_________________________________Date________________

The following section must be completed and signed by the attending physician.
The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form. The Fund's Medical Advisor may contact you if additional information is needed.

1. History

(a) Height_________________Weight_________________Blood Pressure____________________
(b) Date symptoms first appeared or accident happened…………..... Mo._______Day_______Yr.________
(c) Date patient ceased work as a musician because of disability…… Mo._______Day_______Yr.________
(d) Has patient ever had same or similar condition? ☐No ☐Yes, state when and describe.
(e) Is condition due to injury or sickness arising out of patient's employment? ☐No ☐Yes ☐Unknown
(f) Names and addresses of other treating physicians:
Name__________________________Address____
Name__________________________Address____
Name__________________________Address____

2. Diagnosis

(a) Date of last examination…………………..Mo.________Day__________Yr.____________

(b) Primary ICD diagnostic code (**mandatory**)____

(c) Diagnosis (including any complications)____

(d) Subjective symptoms

(e) Objective findings (including current X-rays, EKG's, laboratory data and any clinical findings):
(1.) **Clinical Findings:**

(2.) **Diagnostic Studies and Results:**

(f) Other disease or infirmity affecting present condition____________________________________

3. Dates of Treatment	(a) Date of first treatment (or visit)…………Mo.____________ Day____________Yr.______________ (b) Date of last treatment (or visit)…………Mo.____________ Day____________Yr.______________ (c) Frequency of treatment (or visit)……. ☐ Weekly ☐ Monthly ☐ Other(specify)______________ (d) Is patient still under your care for this condition? ☐ Yes ☐ No, indicate date and reason treatments (or visits) terminated.____________________
4. Nature of Treatment	(a) Type and dates of treatment: (b) Prescribed medications: (c) Surgical procedures and dates:
5. Progress	(a) Patient has………. ☐ Recovered ☐ Improved ☐ Stabilized ☐ Retrogressed (b) Patient is………… ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined (c) Has patient been confined to a hospital previously or currently? ☐ No ☐ Yes, give name and address of hospital____ ____ Confined from____________________________through____________________________________ Date Date
6. Cardiac (if applicable)	Functional capacity limitation (American Heart Association): ☐ Class 1 (none) ☐ Class 3 (marked) ☐ Class 2 (slight) ☐ Class 4 (complete)
7. Limitation	(a) What are patient's present capabilities?____ ____ (b) What are present limitations (physical and/or mental)?__________________________________ ____ (c) What restrictions are placed on patient?____ ____
8. Mental/ Nervous Impairment (if applicable)	Please define "stress" as it applies to this claimant. Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐ No ☐ Yes

9. Prognosis

(a) What is the patient's prognosis?

☐ Good ☐ Fair ☐ Poor ☐ Other

(b) When do you feel patient's maximum medical improvement will be reached?

☐ 1 Mo. ☐ 1-3 Mos. ☐ 3-6 Mos. ☐ 6-9- Mos. ☐ 1 yr or longer ☐ already at maximum improvement or will worsen

(c) Estimated date of the patient's return to work:

☐ As a musician_______________

☐ No return expected

Remarks

Enter additional information

Attending Physician's Name (print)	Registration License No.	Specialty	Degree

Address (No. Street, City, State, Zip Code)	Daytime Telephone
	Fax
Signature of Attending Physician	Date