



AMERICAN FEDERATION OF MUSICIANS AND EMPLOYERS'  
PENSION FUND  
One Penn Plaza • Suite 3115 • New York • New York • 10119

DISABILITY PENSION APPLICATION  
ATTENDING PHYSICIAN'S STATEMENT

- The patient is responsible for completion of this form without expense to the Fund.
- You may use the remarks section on page 3 if you need more room to respond.

<b>The following section must be completed and signed by the Participant/patient.</b> <b>Any fee for the completion of this form is the Participant's responsibility.</b>			Musical Instrument(s)
Name: Last	First	MI	Social Security No.
Home Address			Date of Birth [mm/dd/yy]

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.

<b>1. History</b>	(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? <input type="checkbox"/> No <input type="checkbox"/> Yes, state when and describe.
	(e) Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
	(f) Names and addresses of other treating physicians: Name _____ Address _____ Name _____ Address _____ Name _____ Address _____
<b>2. Diagnosis</b>	(a) Date of last examination.....Mo. _____ Day _____ Yr. _____
	(b) Primary ICD diagnostic code ( <b>mandatory</b> ) _____
	(c) Diagnosis (including any complications) _____
	(d) Subjective symptoms _____
	(e) Objective findings (including current X-rays, EKG's, laboratory data and any clinical findings): (1.) <b>Clinical Findings:</b>  (2.) <b>Diagnostic Studies and Results:</b>
	(f) Other disease or infirmity affecting present condition _____

<b>3. Dates of Treatment</b>	(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)..... <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other(specify) _____ (d) Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No, indicate date and reason treatments (or visits) terminated. _____
<b>4. Nature of Treatment</b>	(a) Type and dates of treatment:  (b) Prescribed medications:  (c) Surgical procedures and dates:
<b>5. Progress</b>	(a) Patient has..... <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Stabilized <input type="checkbox"/> Retrogressed (b) Patient is..... <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed confined <input type="checkbox"/> Hospital confined (c) Has patient been confined to a hospital previously or currently? <input type="checkbox"/> No <input type="checkbox"/> Yes, give name and address of hospital _____  _____  Confined from _____ Date _____ through _____ Date _____
<b>6. Cardiac (if applicable)</b>	Functional capacity limitation (American Heart Association):  <input type="checkbox"/> Class 1 (none) <input type="checkbox"/> Class 3 (marked) <input type="checkbox"/> Class 2 (slight) <input type="checkbox"/> Class 4 (complete)
<b>7. Limitation</b>	(a) What are patient's present capabilities? _____ _____ (b) What are present limitations (physical and/or mental)? _____ _____ (c) What restrictions are placed on patient? _____ _____
<b>8. Mental/ Nervous Impairment (if applicable)</b>	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? <input type="checkbox"/> No <input type="checkbox"/> 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**

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	