Physician's Dismemberment Statement

Patient information

Name (first, middle, last)

Date of birth *(mm/dd/yyyy)*	Social Security number *(last 4 digits)*

Diagnosis and nature of injury

Date first consulted for this loss *(mm/dd/yyyy)*

In your opinion, was this loss the result of an accident? ☐ Yes ☐ No	Did illness or disease contribute to the loss? ☐ Yes ☐ No

If the loss was the result of an accident, please explain

At the time of the amputation or loss, was the patient receiving care or treatment for any disease or illness? ☐ Yes ☐ No

Was the amputation or loss of sight or hearing caused (directly or indirectly) by any physical or mental infirmity, illness, disease, self-inflicted injury, commission of a felony, drugs or poison taken voluntarily, or bacterial infection? ☐ Yes ☐ No

Date of accident *(mm/dd/yyyy)*	Time of accident

Location of accident

Describe the accident that caused the loss

Any contributing medical conditions? ☐ Yes ☐ No	Maximum medical improvement achieved? ☐ Yes ☐ No

Amputation information

Which limb was amputated?

Where is the amputation?
If applicable, please list if above or below wrist or ankle joint

If below the joint, please identify where the amputation occurred

Reason for the amputation

RIGHT LEFT RIGHT LEFT

Additional comments

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711).

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Hearing loss information

Date of loss *(mm/dd/yyyy)*

Is the loss in both ears? ☐ Yes ☐ No

Is the loss total and irrevocable? ☐ Yes ☐ No

Vision loss information

Date of loss *(mm/dd/yyyy)*

Date of first eye exam *(mm/dd/yyyy)*

Date of last eye exam *(mm/dd/yyyy)*

Visual acuity

with glasses OD ________________

OS ________________

Date ________________

uncorrected OD ________________

OS ________________

Date ________________

If fields of vision are contracted, show contraction on chart below

Left Eye

Right Eye

90° 80° 70° 60° 50° 40° 30° 20° 10°

120° 60° 150° 30° 180° 0° 210° 330° 240° 300° 270°

If the injury necessitated the removal of one or both eyes, supply the date of surgery *(mm/dd/yyyy)*

Can vision be restored in whole or part by lenses, treatment, or surgery? ☐ Yes ☐ No

If vision can be restored by surgery, do you recommend it? ☐ Yes ☐ No

Medical records

Please include copies of medical records pertaining to the amputation or loss

Fraud notice

I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

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