



**SHEET METAL WORKERS' LOCAL UNION NO. 73
WELFARE FUND**

4530 ROOSEVELT ROAD
HILLSIDE, IL 60162-2053
708-449-7373



WEEKLY INDEMNITY SUPPLEMENTARY STATEMENT

NAME _____

ADDRESS _____

SOCIAL SECURITY NUMBER _____

MEMBER'S PHONE _____

NAME OF EMPLOYER (COMPANY NAME) _____

I HEREBY CERTIFY THAT I HAVE BEEN

CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM _____ 20____ TO _____ 20____

DATE _____ EMPLOYEE'S SIGNATURE _____

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

PATIENT'S NAME _____ AGE _____

NATURE OF SICKNESS (DESCRIBE COMPLICATIONS, IF ANY) _____

(A) DATE OF FIRST TREATMENT _____ 20____

(B) DATE OF MOST RECENT TREATMENT _____ 20____

(C) FREQUENCY OF TREATMENT _____

THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM _____ 20____ THROUGH _____ 20____

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? _____

REMARKS: _____

DATE _____ 20____

SIGNED _____ M.D.
(ATTENDING PHYSICIAN)

ADDRESS _____

DOCTOR'S PHONE NO. _____