SHEET METAL WORKERS'
International Association • Local Union No. 73
4530 Roosevelt Road | Hillside, Illinois 60162 | 708.449.7373 | FAX 708.449.7333

A HIGHER STANDARD CHICAGO SMACNA

Welfare and Pension Funds

WEEKLY DISABILITY CONTINUATION 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 CONTINUATION 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. _____