Pipe Fitters' Local 597
WELFARE & RETIREMENT FUNDS

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WEEKLY ACCIDENT AND SICKNESS SUPPLEMENTARY STATEMENT

Member's Name _____
First Middle Initial Last

Social Security Number Local 597 Union Card Number

Address _____
Street City State Zip Code

Phone Number E-Mail Address

Employer _____

I hereby certify that I have been Continuously Totally Disabled (unable to work)

From / / To / /

Authorization to Release Information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment. All questions must be answered. Return completed claim form to the Fund Office.

_____ / /
Member's Signature Date

It is the member's responsibility to notify the Fund Office upon physician's release to return to work. If you fail to notify the Fund Office of your return date to employment, you will be responsible to reimburse the Fund in full for any monies paid to you after your return date.

_____ / /
Member's Signature Date

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Nature of Sickness (describe complications, if any)

Dates of First Treatment / / Date of Most Recent Treatment

Frequency of Treatment

The Patient has been Continuously Disabled (unable to work) From / / Thru / /

If still disabled, when should patient be able to return to work? / /

Remarks:

Physician's Name Physician's Degree

Physician's Signature Phone Number

Address _____
Street City State Zip Code

Date / /