

APPLICATION FOR DISABILITY EXTENSION OF ELIGIBILITY

CERTIFICATE OF DISABILITY - To be completed by member

1. Name: _____
2. Soc. Sec. No.: _____
3. Telephone #: _____
4. If disability is the result of an **injury**, enter the accident date: ___/___/___
5. Date(s) you were unable to work: ___/___/___ to ___/___/___
6. Was this accident work-related? Yes No
7. If disability is the result of a **sickness**, enter the date(s) you were unable to work: ___/___/___ to ___/___/___
8. Have you been unable to work in the last 12 months because of a disability? Yes___ No___
If yes, please describe the conditions: _____

Date _____ Signed: _____
(Applicant)

*****YOU MUST NOTIFY THE FUND OFFICE WHEN YOU RETURN TO WORK.*****

CERTIFICATE OF DISABILITY - To be completed by doctor

1. Date of patient's first treatment for condition: ___/___/___
2. Diagnosis: _____

I certify that this patient is/was unable to perform his regular and customary work for the period from ___/___/___ to ___/___/___ because of this disability.

Signed: _____
(Physician)

Physician's Name: _____

Address: _____

Date: _____

Telephone Number: _____