

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	/ /		