# PIPEFITTERS WELFARE FUND, LOCAL 597
# WEEKLY ACCIDENT AND SICKNESS SUPPLEMETARY STATEMENT

**Phone (312) 633-0597 - Fax (312) 829-7787**

**www.pf597.org**

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 / /