Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension

Physician's Statement of Disability

Return completed form to:

Northern California Tile Industry
PO Box 1607
San Ramon, CA 94583

Trust Fund Phone #: (925) 208-9995
Toll Free #: (888) 208-0250
Fax #: (925) 462-0108

Part 1 – To be completed by PARTICIPANT (Each question must be fully answered)

1. Name: _____ 2. Birth date: _____SSN: _____

Street: _____ 3. Last date of work before disability: _____

City and State: _____ Zip code: _____ Member's Phone#: _____

4. My disability is: _____ Injury? _____

Illness? _____

5. It happened: Date: _____ at Work? _____

Time: _____ at Home? _____

6. How did it happen?

_____

7. Job Description?

_____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Northern California Tile Industry Trust Fund any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated: _____ Mr._____ Mrs._____ Miss_____ _____

SIGNATURE – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any): _____

_____

2. Was this sickness or injury caused by patient's employment? Yes_____ No_____

Illness? _____ Injury? _____

Was it aggravated by Patient's employment? If "Yes" explain: _____

3. Nature of surgical procedure, if any/CPT (Describe fully): _____

_____

4. Date performed: _____

5. Give dates of treatments:

FIRST CONSULATION :

Office: _____

Hospital: _____

OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY:

_____

_____

6. The patient has been continuously disabled (unable to work): From: _____

Through (if unsure give tentative date): _____

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

7. Remarks: _____

Date: _____ Physician's Name (Print): _____ Degree: _____

Physician's Signature: _____

Address: _____

Physician's Phone Number: _____