NECA IBEW
LEADING THE ELECTRICAL INDUSTRY

HARRISON TRUST

A FAMILY HEALTH PLAN
WWW.HARRISONBENEFITS.ORG

DISABILITY WAIVER APPLICATION

Return completed form to: PMB #116, 5331 S Macadam Ave, Suite 258 Portland, Oregon 97239

**** THIS SECTION TO BE COMPLETED BY THE EMPLOYEE ****

Employee Name _____ Address _____

Date Employee last worked: _____, 20____. Social Security #: _____

Has Employee returned to work? _____ If so, on what date? _____

Employee Signature: _____ Phone: _____

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CERTIFICATE OF ATTENDING PHYSICIAN

I certify I attended: _____ Age: _____

Is disability due to an accident? _____ Nature of Injury: _____

INJURY Brief History: _____

Symptoms: _____

ILLNESS Objective Findings: _____

Diagnosis: _____

Date of First Medical Treatment: _____

Nature of surgical or obstetrical procedure: _____

Where performed: _____ Date: _____

If in Hospital, In-patient: _____ Out-patient: _____

The patient has been continuously disabled (unable to work) from: _____ to _____

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

Remarks: _____

_____

Date: _____ Signed: _____

Address: _____ Phone: _____

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Local Union Approval: _____

Local Number Signature of Business Agent