Heat & Frost Insulators of Northern California Local 16 Trust Funds

Return completed form to:
Heat & Frost Insulators of Northern California Local 16
PO Box 2684
San Ramon, CA 94583

Trust Fund Phone #: (925) 398-7042
Toll Free #: (844) 685-6409
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 Heat & Frost Insulators of Northern California Local 16 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	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office_____	_____
Hospital _____	_____

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_____