Disabled Children / Michelle's Law Application

PARTS A, B, and C TO BE COMPLETED BY EMPLOYEE (Please Print)

PART A – EMPLOYEE INFORMATION

Employee's Name:	Last	First	Middle Initial	**Social Security Number** / /
Employee's Address	Address			Home Phone Number ( )
	City		State	Zip Code

PART B – DEPENDENT CHILD INFORMATION – *Application for:* Disabled Child ☐ Michelle's Law ☐

Dependent Child's First Name, Middle Initial, Last Name:	**Gender** ☐ M ☐ F	**Date of Birth (Month-Day-Year)** / /
Relationship to Employee:	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	**Date Disability or Change from Full Time Student Occurred:(Month-Day-Year)** / /

Does Child Reside In Your Household? □ Yes □ No If "No", provide an explanation.

Is Child a Full Time Student? ☐ Yes ☐ No	**Is Child Dependent Upon You For Support?** ☐ Yes ☐ No	**What Percentage of Support Do You Provide?**
Was Child Listed as a Dependent On Your Last Federal Income Tax Return? ☐ Yes ☐ No	**Has Child Ever Been Employed?** ☐ Yes ☐ No	**Is Child Currently Employed?** ☐ Yes ☐ No

If Child Has Been or Is Currently Employed, List Employer Name and Address	**Employment Start Date**	**Employment End Date**
	/ /	/ /
	/ /	/ /

Name of Attending Physician Certifying Disability:

Physician's Address	**Address**		**Office Phone Number**
	City	**State**	**Zip Code**

PART C – EMPLOYEE SIGNATURE

I hereby certify that my enrolled dependent child noted above has ceased to be a full-time student at an accredited educational institution on the date noted above because of a serious illness or injury. I further certify that this child is unmarried, receives over half of his/her financial support from me, and qualifies as my dependent for federal income tax purposes (or would qualify if he/she did not exceed the IRS age or earnings limits.) I request that this child remain enrolled as my dependent in the Iron Workers St. Louis District Council Health and Welfare Trust Fund through the Michelle's Law leave of absence for the period of time my child's physician certifies as medically necessary (but not to exceed one year from the date the child ceased to be a full-time student, as permitted under the law). If my child gets married, enters the military, or attains age 23 while on the leave of absence, I will promptly notify Iron Workers St. Louis District Council Health and Welfare Trust Fund.

Employee Signature: _____ Date: ____ Dependent Child's Signature: _____ Date: ____

PART D – ATTENDING PHYSICIAN INFORMATION – TO BE COMPLETED BY ATTENDING PHYSICIAN

Date of injury or date disability/illness began?

Is child incapable of self-support due to a disability/illness/injury? □ Yes □ No

Is child able to attend school on a part time basis? □ Yes □ No **Full time basis?** □ Yes □ No

Date child is expected to return to school full time? **Expected length of disability?**

Reason or Nature Of Disability/Illness/Injury:

PART E – PHYSICIAN CERTIFICATION

I hereby certify that I am a licensed physician treating the above noted patient and that he/she is suffering from a serious illness or injury and that a leave of absence, as permitted under Michelle's Law, is medically necessary.

Physician's Name (Please Print) _____ **Physician's Field of Medical Specialty** _____

Physician's Address_____
Street **City** **State** **Zip code**

Physician's Signature _____ **Tax ID**_____ **Date**_____