Utah Pipe Trades Trust Funds
Temporary Total Disability

Return completed form to:

Utah Pipe Trades Funds
PO Box 1975
San Ramon, CA 94583

Trust Fund Phone #: (925) 398-7041
Toll Free #: (877) 416-8181
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 Teamsters and Food Employers Security 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_____