IUPAT District Council 16 Trust Funds Temporary Total Disability

Return completed form to:

IUPAT District Council 16 Trust Fund Trust Fund Phone #: (702) 415-2191
Fax #:(702) 257-5361 PO Box 400608 Las Vegas, NV 89113

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 IUPAT District Council 15 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_____
