

Phone: (518) 785-3440

**WELFARE FUND
PLUMBERS AND STEAMFITTERS LOCAL NO.7
18 AVIS DRIVE, LATHAM, N. Y. 12110**

**LOSS OF TIME BENEFITS
CLAIMANT'S SUPPLEMENTARY REPORT**

This report should be completed in full and returned to the Fund Office as soon as possible. Further benefits will be delayed until this form is received.

What is your general condition at this time? _____

What now prevents your returning to work? _____

Have you been discharged by your doctor? _____

On what dates did you personally call at the doctor's office for treatment? _____

On what date do you expect to be available for work _____

Have you, or do you intend to file this claim under any Workmen's Compensation or Occupational Disease Law?

Remarks: _____

Signed _____

Date: _____ Address _____

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name _____

Diagnosis and Concurrent Conditions _____

Date of First Treatment _____

Date of Most Recent Treatment _____

Frequency of Treatments _____

The Patient has been continuously disabled (unable to work) from _____ through _____

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

Remarks: _____

Signed _____ Degree _____

Date _____ Address _____