

SAN FRANCISCO ELECTRICAL WORKERS HEALTH AND WELFARE TRUST

720 Market Street, Suite 700, San Francisco, CA 94102

Phone (415) 263-3670 • FAX (415) 263-3672

PHYSICIAN'S STATEMENT OF DISABILITY

FOR LONG TERM DISABILITY AND/OR DISABILITY HEALTH & WELFARE COVERAGE

NOTE: THIS FORM TO BE COMPLETED BY A LICENSED DOCTOR

Name of Patient: _____ SSN: _____

Present Address: _____

Signature of Patient: _____ Date: _____

DOCTOR-PLEASE NOTE:

THIS DISABILITY PLAN'S CRITERIA FOR DISABILITY DIFFERS AND IS INDEPENDENT FROM CRITERIA USED BY WORKER'S COMPENSATION CARRIERS. **PLEASE EVALUATE PATIENT ACCORDING TO JOB DESCRIPTION LISTED BELOW.**

JOB DESCRIPTION FOR FIRST 12 MONTHS OF DISABILITY

The following job description for Inside Wiremen can be used as a criteria for medical evaluation and analysis of a claimant's disability for the first 12 months of disability:

"To be an Electrical Industry Inside Wireman requires physical stamina and mental aptitude. Good vision, mechanical ability and finger dexterity are essential. The Trade requires climbing, crawling, crouching and working in cramped quarters, carrying loads up to 50 pounds, and the ability to pull wire up to 50 pounds."

*****NO LIGHT DUTY OR MODIFIED WORK FOR ELECTRICIANS*****

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Trust

Date patient ceased work because of disability	Month _____ Day _____ 20 ____
Date of first visit	Month _____ Day _____ 20 ____
Date of visit nearest date patient ceased work	Month _____ Day _____ 20 ____
Date of last visit	Month _____ Day _____ 20 ____
Approximately how long will patient be continuously and totally disabled and unable to work at his trade? (See Job Description above)	From _____ Through _____ <input type="checkbox"/> Permanently

Diagnosis and Physician's remarks:

Date: _____ Physician's Name (Please print or type) _____

_____, M.D.
Physician's Signature

Street Address _____ City or Town _____ Phone Number _____