

RETURN COMPLETED  
FORM TO:

INTERNATIONAL UNION OF OPERATING ENGINEERS WELFARE FUND  
OF EASTERN PENNSYLVANIA AND DELAWARE  
1375 VIRGINIA DRIVE, SUITE 102, FORT WASHINGTON, PENNSYLVANIA 19034

**CONTINUED DISABILITY FORM**

Report of continued disability

**TO BE COMPLETED BY MEMBER**

Claimant's Full Name ..... Date of Birth .....

Claimant's Address..... Social Security Number .....

Company Employed by.....

Are you still totally disabled.....

If not, date disability ended.....

If not, on what date did you return to work.....

**CERTIFICATE OF ATTENDING PHYSICIAN**

Present diagnosis of illness or injury .....

Is patient still totally disabled .....

When do you believe patient will be able to return to work .....

Does the patient's present physical condition prevent him from performing his regular work .....

Remarks.....

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I hereby certify that this statement is based on my personal knowledge of the case:

Date \_\_\_\_\_ Physician's Name (Print) \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ Degree \_\_\_\_\_

Street Address \_\_\_\_\_

City or Town \_\_\_\_\_ State or Province \_\_\_\_\_ Zip Code \_\_\_\_\_