

*International Union of Operating Engineers Welfare Fund  
Of Eastern Pennsylvania and Delaware*

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**REPORT OF CONTINUED DISABILITY**

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**To Be Completed By Member**

1. Name \_\_\_\_\_ SS# XXX-XX-\_\_\_\_\_
2. Are you still unable to work because of total disability? Yes \_\_\_\_\_ No \_\_\_\_\_
3. If not, on what date did the disability end? \_\_\_\_\_
4. If not, on what date did you return to work? \_\_\_\_\_
5. Have you been attended by a physician since the date of the last report?  
Yes \_\_\_\_\_ No \_\_\_\_\_
6. Have you received, since the commencement of your disability, any payments from  
Unemployment Compensation? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list dates  
received \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**To Be Completed By the Attending Physician**

Physician must be an M.D. or a D.O.

1. Name of Patient \_\_\_\_\_
2. Diagnosis(ICD 9 Codes) \_\_\_\_\_
3. Are there any new complications since date of last report? \_\_\_\_\_ If yes, give  
details \_\_\_\_\_  
\_\_\_\_\_
4. Is the patient still totally disabled? Yes \_\_\_\_\_ No \_\_\_\_\_
5. When, in your opinion, will he/she be able to return to work? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

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