

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

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REPORT OF CONTINUED DISABILITY

To Be Completed By Member

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

Signature _____ Date _____

To Be Completed By the Attending Physician

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

1. Name of Patient _____ DOB: _____
2. Diagnosis(ICD 10 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 _____