International Union of Operating Engineers Welfare Fund
Of Eastern Pennsylvania and Delaware
1375 Virginia Drive Suite 245 Fort Washington PA 19034
Phone (215)542-8211 gina.pastella@iuoe542funds.com Fax (215)447-5003

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 _____