SHORT TERM DISABILITY BENEFITS

Section 1:	**To be completed by Employee**		
Name of Employee:	Social Security No.		
Address:			
Is Claim for an Injury ____Yes ____No	If yes, date of injury	How and where did injury happen:	
Has been unable to work: ____Yes ____No	Date first unable to work:	Date returned to work:	Is illness or injury due to Employment? _____Yes ____No
Has or will a claim be filed with Workers Compensation or F.E.I.A. _____Yes _____No			
I hereby authorize my attending physician to furnish the Fund Office with full information regarding treatment, diagnosis and prognosis. Date:_____ Signature of Employee_____			

Section 2:	**To be completed by Employer**
First scheduled work date unable to work:_____ Date returned to work:_____Not returned:_____ Signature of Employers Representative and title:_____	

Section 3:	**Attending Physician's Statement of Disability**
Patients Name:	Date of birth:
Nature of sickness or injury including ICDA Code:	
Is condition due to injury or sickness arising out of patient's employment? _____Yes _____No	
Pregnancy? If yes, approximate date of pregnancy commenced: Date_____ Yes_____ No_____	
Date symptoms first appeared or accident happened:	Date patient first consulted you for this condition:
Patient ever had same or similar condition? If yes, when?	Patient still under your care for this condition: _____Yes _____No
Patient has been continuously disabled (unable to work) from: through:	Patient was partially disabled: from: through:
If still disabled, date patient should be able to return to work:	Patient was house confined from: through:

Physicians Phone:_____ Physicians Signature:_____

Physicians Name (print)_____Tax ID:_____

Physicians Address:_____

Date:_____

Please send back to:
Southwest Ohio Regional Council of Carpenters Health and Welfare Fund
33 Fitch Blvd
Austintown, Ohio 44515 1-800-435-2388 Phone 330-270-0912 Fax