

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:
Ohio Carpenters Health Fund
33 Fitch Blvd
Austintown, Ohio 44515

1-800-435-2388 Phone

330-270-0912 Fax