

DISABILITY CERTIFICATE

Part A – TO BE FILLED OUT BY THE MEMBER

Name of Patient: _____

Address: _____
(Street No.) (City) (State) (Zip)

Social Security #: _____ - _____ - _____ Phone #: (_____) _____ Local Union #: _____

I hereby authorize my Physician to release any of my medical records required by the Medical Consultant for the California Ironworkers Field Pension Trust, in order to determine my qualifications for a Disability Pension under the Plan.

Date: _____ / _____ / _____ Member Signature: _____

Part B – TO BE COMPLETED BY THE PHYSICIAN

This is to certify that the above named Individual was unable to work at his trade from _____ Date
to _____ Date because of his total disability.

The following information is offered in support of this certification:

1. Nature of disability – Diagnosis: _____

2. History: _____

3. Pertinent Lab and X-Ray Findings: _____

PLEASE PROVIDE HAND WRITTEN RECORDS, LAB AND X-RAY REPORTS

4. Date you first examined patient for above condition: _____
5. Was hospitalization necessary in connection with above condition? Yes _____ No _____
6. Date injury occurred: _____ / _____ / _____ Date of next treatment: _____ / _____ / _____
7. Is the patient totally and permanently unable, as a result of bodily injury or disease, to engage in any further employment as an Ironworker, or as any type of building trades craftsman, and will such disability be total, permanent and continuous for the remainder of the life of the patient? Yes _____ No _____

(TYPE OR PRINT DOCTOR'S NAME)

(DOCTOR'S SIGNATURE)

Address: _____

Doctor's Phone Number: _____ Date: _____ / _____ / _____

Send To: **CALIFORNIA IRONWORKERS FIELD WELFARE PLAN**
131 N. El Molino Ave., Ste 330
Pasadena, CA 91101-1878