ROOFERS LOCAL NO. 74/NO. 203
HEALTH & WELFARE FUND

2800 Clinton Street, West Seneca, New York 14224
Phone: (716) 828-0488 Fax: (716) 828/0487 Toll Free 1-800-905-0904

SUPPLEMENTAL WEEKLY ACCIDENT AND SICKNESS BENEFIT PHYSICIAN'S VERIFICATION STATEMENT

Claimant's Name:_____

Address: _____
Street

_____
City, State Zip

Social Security No. _____

PHYSICIAN - *PLEASE LIST THE FOLLOWING INFORMATION:*

Diagnosis/Analysis: _____

Is this Disability due to: Occupational Injury _____ (or) Illness _____

Has Claimant been hospitalized? _____ Date (s): _____*:*

Date of your first treatment for this disability? _____

Date claimant was unable to work due to this disability:_____

Date of your most recent treatment: _____

Date claimant will return to work***:**_____
***Claimant must submit another form if return to work date needs to be extended**

Physicians Name: _____
(Please print)

Address: _____

Telephone Number: Area code _____ Number _____

I certify that I am a licensed physician in the State of _____

License No. _____

Signature of Physician Date