Operating Engineers Locals 14 and 14B Welfare Fund

141-57 Northern Boulevard • Flushing, New York 11354 • (212) 939-1489

CONTINUED CLAIM FOR DISABILITY BENEFITS

THE DOCTOR'S STATEMENT MUST BE FILLED IN COMPLETELY TO PREVENT DELAY IN THE PAYMENT OF DISABILITY BENEFIT PAYMENTS.

DOCTOR'S STATEMENT

1. Claimant's Name _____ (First / Middle / Last) 2. Age _____

3. Diagnosis: _____

_____

4. Operation Indicated? ☐YES ☐NO a. Type _____ b. Date _____

5. Enter Dates for the following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will be able to perform usual work			

Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.

6. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐YES ☐NO

Remarks: _____

Physician's Name (please print) _____

Office Address _____ (Number / Street / City or Town / State / Zip Code)

W.C.B. Authorization Registration No. _____ W.C.B. Rating Code _____

Date _____ Physician's Signature _____

RETURN THIS FORM COMPLETED IN FULL ON OR AFTER _____ **Claimant's Signature** _____ **Date** _____