IBEW Local 269 Welfare Fund
Certification For
Posting Temporary Disability Hours

(To Be Completed by Your Attending Physician)

Patient's Name _____ Soc. Sec. # _____

Nature of Illness or Injury (describe complications, if any) _____

_____

_____

Did this illness arise out of the patient's employment? _____

Date of first treatment _____

Date of most recent treatment _____

Frequency of treatments _____

This patient has been continuously disabled (unable to work) from:

_____ to _____

When should patient be able to return to work? _____

Remarks: _____

_____

_____

_____

Physician's Name (print) _____

Physician's Address _____

Physician's Telephone # _____

_____ _____
Physician's Signature Date

Please return completed form to: I. E. Shaffer & Co., P.O. Box 1028, Trenton, NJ 08628