

**IBEW Local 351 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