IBEW Local 400 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) _________________________

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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: ____

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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