

MASS. LABORERS' HEALTH & WELFARE FUND

14 New England Executive Park, Suite 200 • Burlington, MA 01803-5201 • (781) 272-1000

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

TO BE COMPLETED BY MEMBER

Name _____ Social Security No. _____

Address _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

Are you still disabled? Yes No If "No", give date of your ability to return to work _____ 20 _____

Date _____ 20 _____ Signature _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Name _____

Diagnosis _____ ICD Code: _____

CPT Code: _____

Describe Complications (if any) _____

List Dates of Most Recent Treatments _____

The patient has been continuously disabled (unable to work) from _____ 20 ____ through _____ 20 ____

If still disabled, when should patient be able to return to work? _____ 20 ____

Remarks: _____

Date _____ 20 ____

Signed _____
(ATTENDING PHYSICIAN)

Address (*Type or Print*) _____

Tax I.D.# _____