Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds

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For Fund Office Use Only

Inc. __________ Date:____________
Pd from ______________ through ________
By:________________Claim # ___________
Follow up sent Yes No

Disability Continuance Form

Please note: No further disability will be paid until the appropriate section of this form is completed and returned to the Fund Office.

Part 1: If you continue to be disabled, an up-to-date out of work excuse or Part 1 of this form must be completed by your physician.

1. Patient's full name ____ SSN or UID ________________
2. Nature of sickness or injury ____
3. Is this work related? Yes No
4. a. Date of first treatment ____________________________

   b. Date of most recent treatment _____________________
5. The patient has been continuously disabled (unable to work) from _____________________ and should be able to return to work on ______________________ (Please give an approximate date if possible).
6. Physician's Name (please print) ______________________________________ Phone No.________________

   Physician's Signature:____ Date _________________________

Part 2: If you have returned to work, this section must be completed by your employer.

Employee's Full Name____ SSN or UID:_________________

Name of Company ____ Phone No. _________________

Date Returned to Work ________________________________

Employer's Signature _____________________________________ Position_______________ Date__________