DISABILITY FORM

WV LABORERS'
TRUST FUND
ONE UNION SQUARE - SUITE 200
CHARLESTON, WV 25302

Instructions: This form must be submitted by the individual claimant to the Fund office property and fully completed and signed by himself, and his physician.

PART 1. ATTENDING PHYSICIANS SUPPLEMENTARY STATEMENT (Must be completed in full)

1. Patient's Name _____
2. Nature of ( ) Sickness or ( ) injury ICD Code Number _____
   Describe any complications, if any _____
   _____
   is this work related? Yes No
3. a. Date of first treatment _____
   b. Date of most recent treatment _____
   c. Frequency of treatments _____
4. 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).
5. Physicians Name (type or print) _____
   Date _____ IRS or SS# _____ Phone # _____
   Physician's Signature: _____
   Complete Address: _____
   _____

PART 2. EMPLOYEE'S STATEMENT (Must be completed in full)

1. Employee's Full Name _____ SS# _____
2. Home Address _____
3. Are you still totally disabled by this sickness or injury? _____
4. Are you now wholly unable to physically engage in any work, occupation, or business? _____
5. On what date were you last treated by a physician? _____
6. Have you returned to work? _____ if so, on what date? _____

Date: _____ Signature of insured employee _____