TEAMSTERS LOCAL UNION NO. 301

Short Term Disability and Fraternal Dues Rebate Application

SECTION I: TO BE COMPLETED BY THE MEMBER

Last Name	First	M.I.	Date
Street Address:		Apartment/Unit #	
City	State	ZIP	
Phone	Social Security No.		
Date you last worked?	Date you expect to return to work?		

Disability due to: ☐ ILLNESS ☐ INJURY – Type: ☐ Auto ☐ Workers' Compensation ☐ Home ☐ Other

The statements contained in this form are true and complete to the best of my knowledge and belief.	Date
X _____ Signature of member	

SECTION II: TO BE COMPLETED BY THE EMPLOYER

Date Employee Last Worked:	Date Employee Returned to work:
Is this worker on lay off status: ☐ YES ☐ NO	Please indicate if any of the time off was vacation time or paid sick leave. ___/___/_____ to ____/____/____

Did injury or illness arise out of or in course of employment ? ☐ YES ☐ NO

Printed name of employer representative	Title	Phone No.
Signature of employer representative		Date

SECTION III: TO BE COMPLETED BY PHYSICIAN

Current diagnosis:

Has patient ever had same or similar condition: ☐ YES ☐ NO If yes, please specify dates of treatment:	Did injury or illness arise out of or in course of employment? ☐ YES ☐ NO ☐ UNKNOWN
Was patient hospitalized? ☐ YES ☐ NO If yes, please provide dates of confinement and name of hospital/facility?	Name of surgical procedure, if any. Date performed : _____ /_____ /_____

TREATMENT

The patient has been continuously disabled (unable to work) From _____ through _____	Patient's present condition ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed

Date of first visit:	Date of last visit:	Frequency of visits: ☐ Weekly ☐ Monthly

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

Remarks:

Physician Signature:	Date: