BUILDING TRADES HEALTH AND WELFARE FUND OF HARRISBURG, PENNSYLVANIA

CLAIMANT'S SUPPLEMENTARY STATEMENT

FULL NAME__________ Certificate No. __________ Claim No.__________

Name and address of physician (Give names of all physicians consulted)	
Give dates of treatment since last report.	Office: Home: Hospital:
Have you been confined to a hospital since last report? Name and address of hospital	Admitted 19 Discharged 19
On what date did you or do you expect to resume light work? On what date did you or do you expect to resume your usual duties?	19 19

Date__________ Signed__________

__________ __________ __________
Address City - Town State

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

— ACCIDENT OR SICKNESS —

Patient's Name	
Give dates of treatments.	Office: Home: Hospital:
Is patient still under your care for this condition? If discharged, give date.	Yes ☐ No ☐ Date 19
How long was or will patient be continuously totally disabled (unable to work)? Please give approximate time.	From 19 through 19

REMARKS

Date__________, 19____ Signed__________ Degree
(Attending Physician)

____
(Street Address) (City or Town) (Zone) (State)