

Local 292 Health Care Plan

Loss of Time Application Physician Continuation Form

It is the responsibility of the member to see that all sections of this form are complete, questions answered and the form returned to the plan office at 6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196

Please Type or Print

1. Patient's Name _____

2. Name of illness/injury _____

Was patient confined to a hospital overnight? _____

3. Surgical procedures, if any, _____ Date performed _____

4. Date patient first consulted you for this condition _____

5. Date of most recent treatment _____

6. Frequency of treatment(s) _____

7. If pregnancy, please give delivery date _____

8. Date employee first unable to work due to disability _____

9. Is the employee now, and has the employee been, continuously disabled from performing their job from the above date?
Yes _____ No _____ Remarks, if any _____

10. When will the employee be able to return to work? (Give approximate date) _____

11. In your opinion, is the disability the result of illness or injury arising out of or in the course of employment: Yes _____ No _____
If yes, please explain _____

12. Remarks _____

Date signed _____ Doctor's Signature _____

Doctor's Name _____

Address _____

Send Medical Records

Phone Number _____

Doctor's I.D. Number _____

I hereby authorize release of medical information to IBEW Local #292 Health Care Plan to receive Loss of Time Benefits and do certify that the above statement is true. I also authorize release of workability to the #292 Hiring Hall.

Date: _____ Employee's Signature _____