Local 292 Health Care Plan

Loss of Time Application
Attending Physician Statement

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 _____