CALIFORNIA FIELD IRONWORKERS TRUST FUNDS

Pension Trust • Welfare Plan • Vacation Trust
Apprenticeship Training & Journeyman
Retraining Fund • Annuity Trust

DISABILITY CERTIFICATE

Name of Member: _____

Address: _____
(Street) (City) (State) (Zip)

Social Security #: _____-_____-_____ Phone #: (_____)_____ Local Union #: _____

I hereby authorize my Physician to release any of my medical information and/or records requested by the California Field Ironworkers Trust Funds, as necessary to determine my qualifications for certain benefits under the Plan.

Date: _____/_____/_____ Member Signature: _____

**** THIS SECTION TO BE COMPLETED BY PHYSICIAN ****

This is to certify that the above named individual was unable to work at his trade for the following period due to total disability. *DATES MUST BE GIVEN BELOW OR THIS FORM WILL BE RETURNED*

_____ **through** _____
Beginning Date of Disability Ending Date of Disability

1. Nature of Disability: _____

2. History: _____

_____

3. Date you first examined patient for above condition: _____

4. Was hospitalization necessary in connection with the above condition? Yes _____ No _____

5. Is the patient totally and permanently unable, as a result of bodily injury or disease, to engage in any further employment as an Ironworker, or as any type of building trades craftsman, and will such disability be total, permanent and continuous for the remainder of the life of the patient? Yes _____ No _____

_____ _____
(TYPE OR PRINT DOCTOR'S NAME) (DOCTOR'S SIGNATURE)

Address: _____

Doctor's Phone Number: _____ Date: _____/_____/_____

Return Completed Form Along w/ Any Pertinent Hand Written Records to be considered:

CALIFORNIA IRONWORKERS FIELD WELFARE PLAN
131 N El Molino Avenue Suite 330
Pasadena CA 91101-1878