

**APPLICATION FOR DISABILITY EXTENSION OF ELIGIBILITY**

**CERTIFICATE OF DISABILITY - To be completed by member**

1. Name: \_\_\_\_\_
2. Soc. Sec. No.: \_\_\_\_\_
3. Telephone #: \_\_\_\_\_
4. If disability is the result of an **injury**, enter the accident date: \_\_\_/\_\_\_/\_\_\_
5. Date(s) you were unable to work: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
6. Was this accident work-related? Yes  No
7. If disability is the result of a **sickness**, enter the date(s) you were unable to work: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
8. Have you been unable to work in the last 12 months because of a disability? Yes\_\_\_ No\_\_\_  
If yes, please describe the conditions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signed: \_\_\_\_\_  
(Applicant)

**\*\*\*YOU MUST NOTIFY THE FUND OFFICE WHEN YOU RETURN TO WORK.\*\*\***

**CERTIFICATE OF DISABILITY - To be completed by doctor**

1. Date of patient's first treatment for condition: \_\_\_/\_\_\_/\_\_\_
2. Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

I certify that this patient is/was unable to perform his regular and customary work for the period from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_ because of this disability.

Signed: \_\_\_\_\_  
(Physician)

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_