PHYSICIAN'S SUPPLEMENTARY REPORT

Return this completed form to:
EMPLOYMENT PARTNERS BENEFITS FUND
50 Abele Rd, Ste. 1005, Bridgeville, PA 15017
Telephone: 412-363-2700 Toll Free: 1-800-242-0410 Fax: 412-363-0580
Website: www.wpawelfarefund.com
Email: kceoffe@epbfund.com

Certificate of Attending Physician

(To be furnished without expense to the Welfare Fund)

S.S. No_____

1. Name of Employee (patient)_____
2. Home Address_____
3. Employed by_____
4. Nature of sickness or injury_____
5. Is the patient unable to return to work at this time?_____
6. If still disabled, when should the patient be able to return to work?_____

If physician cannot determine a return to work date, this form is only verified for 30 days from physician's signature

Date_____20_____ Phone_____

Signed_____(attending physician)

To be completed by the Employer

Has Employee returned to work?_____ If so, on what date?_____

Physician has released Employee on _____
(If Employee returns to work before this date please notify the Fund)

If physician cannot determine a return to work date, your signature will be required every 30 days

Date_____ Telephone No. _____

Signature of employer _____