HOLLOW METAL TRUST FUND

395 Hudson Street New York, NY 10014

Inquires
(212) 366-7880

ATTENDING PHYSICIANS'S SUPPLEMENTAL STATEMENT

Name of Patient: _____ UBC#: _____

Address: _____ Telephone #:_____

Local Union#: _____ Commencing date of Disability: ____

1. Date you first treated patient for present disability:
2. Is he/she now under your care?
3. How often do you see this patient?
4. What is the nature and cause of the present disability?
5. Is the patient totally disabled at this time? Yes/No If no, please provide date that total disability ended.
6. Can treatment be successfully rendered while at work?
7. When, in your opinion, should this patient be able to return to his/her regular employment?
8. If answer to #7 is undetermined, please state approximate date the patient can return to work.

Dr.'s Name (please print):_____
Dr.'s Signature: _____
Dated: _____ Telephone #_____

TO BE COMPLETED BY THE PATIENT

Have you returned to work?
If yes, give date you returned to work.