STATEMENT OF CONTINUANCE OF DISABILITY Form to be Completed and Returned To:

OHIO LABORERS' DISTRICT COUNCIL - OHIO CONTRACTORS' ASSOCIATION INSURANCE FUND
800 Hillsdowne Road • Westerville, OH 43081-3302
TEL 614-898-9006 • 1-800-236-6437 • FAX 614-898-9176

INSTRUCTIONS: This form must be completed and signed by the Member and physician and returned to the Fund Office.

TO BE COMPLETED BY INSURED EMPLOYEE	
1. What is your full name?	Social Security Number
2. Are you still totally disabled by this sickness or injury?	
3. On what date were you, or will you be able to return to work?	
4. On what date were you last treated by a physician?	
5. Have you returned to work?	If so, on what date?
Date:	Signature of Insured Employee:

DISABLING PHYSICIAN'S SUPPLEMENTARY STATEMENT	
1. Nature of sickness or injury (Describe complications, if any):	
2. a. Date of first treatment	b. Date of most recent treatment
c. Frequency of treatments	
3. The patient has been continuously disabled and unable to work: From To	If still disabled, when is the estimated return to work date: Date Required
4. Date of patient's next appointment	
5. Remarks:	
Attending Physician's Signature Degree:	Date:
Address (Street, City, State, Zip Code):	Phone: