1199SEIU National Benefit Fund

Disability Department, 330 West 42nd Street, 6th Floor, New York, NY 10036-6977 • www.1199SEIUFunds.org
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SUPPLEMENTAL MEDICAL INFORMATION GENERAL

This form is strictly confidential. **Please print clearly in black or blue ink.**
This form must be completed and returned to the Funds so that disability benefits can continue without interruption.

Member's full name | Member's ID # | Member's job title

Primary diagnosis

Secondary diagnoses and operative procedures (if any)

EXAMINATION PERFORMED AND POSITIVE FINDINGS RELEVANT TO DISABILITY:

Physical examination

REVIEW OF:

A. X-ray report(s): _____ **B.** Surgical report(s): _____

C. Laboratory results: _____ **D.** Other test(s): _____

If patient is not able to return to work, explain briefly and precisely how positive findings prevent the patient from performing his or her usual work:

Please list any suggestions for work modification, different therapy or a prognosis for chronic or recurrent conditions (use additional pages if necessary):

Dates of treatment: _____

THE FOLLOWING ADDITIONAL REPORTS ARE REQUIRED (IF NECESSARY):

☐ Hospital discharge summary
☐ Surgeon's operative report
☐ Other (specify): _____

AS A RESULT OF THIS EXAMINATION AND THE DATA AVAILABLE, I FIND THIS INDIVIDUAL:

☐ Able to return to work
☐ Not able to return to work

Anticipated date of return to work: _____/_____/_____ (Please give your best estimate, even if prognosis is uncertain.)
Month Day Year

Physician's name | Specialty

Social Security #/TIN | Phone number

Address | City | State | Zip code

X _____
Physician's signature (REQUIRED) **Date (REQUIRED)**