I.L.A. LOCAL 1351
7524 Avenue N
Houston, TX. 77012
(713) 923-2839

DISABILITY CLAIM FORM

MEMBER'S NAME: _____ **SS#**_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any licensed physician, hospital, clinic, or other medical or medically-related facility where I have been confined, examined, or treated, to release any and all such information and records to ILA LOCAL 1351 or ITS AUTHORIZED REPRESENTATIVE, upon its request, for the purpose of determining my eligibility for seniority.

SIGNATURE: _____ **DATE SIGNED:** _____

PHYSICIAN'S STATEMENT

Patient's Name: _____ **Date of Birth:** _____

Diagnosis: _____

Dates Patient was totally disabled (unable to work): From _____ **To:** _____
Partially disabled: From _____ **To:** _____

If partially disabled, did this disability prevent him/her from working? **Yes/**_____ **No/**_____

If still totally disabled, what date should patient be able to return to work? _____

Was Patient hospitalized for this condition? **Yes/**_____ **No/**_____

Dates of hospitalization: **From:** _____ **To:** _____

Name and address of hospital: _____

_____

Physician's Signature: _____ **Date Signed:** _____

Physician's Name, Address, and Telephone Number: _____

_____

Phone: _____ _____

DEADLINE for filing this claim form is prior to **October 1st of the year following the close of the contract year in question** in order to be eligible to receive the sick time hours.