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:<br>From To | If still disabled, when is the estimated return to work date:<br>Date Required |
| 4. Date of patient's next appointment | |
| 5. Remarks: | |
| Attending Physician's Signature Degree: | Date: |
| Address (Street, City, State, Zip Code): | Phone: |