Mo-Kan Sheet Metal Workers Welfare Fund

P.O. Box 300019
Kansas City, MO. 64130-0019
Phone: (816) 531-0334 Fax: (816) 753-7252

Loss of Time

EMPLOYEE COMPLETES

1. Employees name: First: Last:	**2. Sex:**	**3. Date of Birth:**	**4. Employee SSN:**
5. Employees Address:	**6. City:**	**State:**	**Zip Code:**
7. Employed By:	**8. Employer Address:**		
9. Local #:	**10. Date Last Worked:**	**11. Dated Returned to work:**	**Member Illness/Injury** ☐ Yes ☐ No **Member Maternity Leave** ☐ Yes ☐ No **Paternal Leave** ☐ Yes ☐ No

12. Is Condition Related to: Patient's Employment ☐ Yes ☐ No
Auto Accident ☐ Yes ☐ No
Any Other Accident ☐ Yes ☐ No

13. If Related to an Accident:
Date:_____
Where:_____
How:_____

14. I certify that the above statements are correct and hereby authorize any doctor or organization to provide pertinent records to Mo-Kan Sheet Metal Workers Welfare Fund upon request.

Employee Signature _____

15. Member Maternity/Paternal Leave Information:

Dates Requested for paternal Leave: **From**: _____ **Through**:_____.
(Please note there is a two week maximum allowance. One week for vaginal birth or placement for adoption or foster care, and two weeks maximum for cesarean section birth)

Delivery Type: _____Vaginal_____Cesarian Section. **Spouses Name:** _____.

DOCTOR COMPLETES

16. Date Illness (First Symptom) or Injury (Accident or Pregnancy)	**17. Date First Consulted for this Condition:**	
18. Has Patient Ever Had Same or Similar Symptoms? ☐ Yes ☐ No	**19. Date Patient Able to Return to Work:**	**20. Dates of Total Disability:** **From:**_____**Through:**_____.
21. For Services Related to Hospitalization, Give Hospitalization Dates: **Admitted:** _____ **Discharged:** _____.		**22. Was this Condition Related to Patient's Employment?** ☐ Yes ☐ No

23. Diagnosis or Nature of Illness of Injury:
1.
2.
3.
1.

24. I hereby certify that all the information in this section is accurate and complete to the best of my knowledge. **Doctor's Signature** _____	**25. Telephone Number:**
	26. SS# or Tax ID#:
27. Doctor's Address (Please Print):	**28. Doctors Printed Name & Credentials:** ***** Doctor Must be a M.D. or D.O.*****