

**PLUMBERS LOCAL UNION NO. 78
1111 W JAMES M WOOD BLVD
LOS ANGELES, CA 90015**

**PHYSICIAN'S SUPPLEMENTARY CERTIFICATE
(To be completed by your present physician)**

1. Name of patient: _____.
2. Patient has been disabled and unable to perform his normal course of work from (date) _____.
3. Does patient continue to be treated? _____ YES _____ NO
4. Date patient recovered or will recover sufficiently, including under treatment, to be able to perform his regular and customary work: _____.
5. Doctor's diagnosis of illness or injury: _____

I hereby certify that the above statements in my opinion truly describe the claimant's condition and the estimated duration thereof.

(Physician's signature)

(Date)

(Physician's address)

(Physician's phone no.)

Member Name _____

Social Security No. _____

(Member's signature)

(Date)

FOR OFFICE USE