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