SANITARY TRUCK DRIVERS & HELPERS LOCAL NO. 350

AFFILIATED WITH I.B. of T.C.W. and H of A
295 89th Street, Suite 304, Daly City, CA 94015
Office: 650-757-7290 Fax: 650-757-7294

APPLICATION FOR SICK BENEFIT

I, the undersigned Member in good standing, as prescribed by the Constitution and By-Laws of the above Local Union hereby apply for the Sick Benefit in accordance with the provisions of said By-Laws and Constitution.

Name:_____ Social Security:_____

Address:_____
No. and Street City or Town State Zip Code

Phone No.:_____ Company:_____

REPORT OF CLAIM – TO BE COMPLETED BY MEMBER

Date of injury/illness:_____ Date last worked:_____
Return to work date:_____ Nature of injury/illness:_____
Name of Physician:_____ Phone No.:_____

*If released to light duty, please list all days worked. From _____up to and including_____

Member's Signature:_____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

1. Patients Name:_____ Age: _____
2. Nature of sickness or injury:_____
3. Nature of surgical procedure, if any (Describe fully)

   _____.
4. How long was or will patient be "Continuously Disabled"? From:_____Through:_____
5. How long was or will patient be "Partially Disabled"? From:_____Through:_____
6. Please list any dates worked while "Partially Disabled"(If applicable):_____
7. Approximate date, patient should be able to resume his/her regular work?_____

   Physician's Name:_____

   Address:_____
   No. and Street City/Town State Zip Code

   Physician's Signature:_____ Date: _____