SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 486-3640 | www.scptac.org

PROGRESS REPORT FORM
Weekly Accident & Sickness (Total Disability) Benefits

PART 1 – SUMMARY

Participant Name _____ Date of Birth _____

Weekly Accident and Sickness (Total Disability) benefit previously approved for: Disability due to: ☐ Accident ☐ Illness

First day of originally approved benefit _____ Last day of originally approved benefit _____

PART 2 – PHYSICIAN'S SUPPLEMENTARY STATEMENT

☐ M.D.
☐ D.O.

Physician name (please print) _____ Phone number _____

Address _____

Nature of Participant's Illness or Injury _____

Diagnosis Code _____ Please attach any additional remarks you believe may be helpful to the Fund in rendering a decision.

If the Participant is still disabled, date you expect him or her to be able to return to work: _____

What complication occurred, if any, which extended the duration of the Participant's Total Disability beyond what would normally be expected for this type of illness or injury?

_____

I certify that the Participant listed above has been Totally Disabled, which is defined by the Fund as "wholly prevented by bodily Injury or Illness from engaging in any occupation or employment", during the period(s) indicated.

X _____ _____
Physician Signature Date