RESILIENT FLOOR COVERING PENSION FUND

4160 Dublin Blvd ♦ Suite 400 ♦ Dublin, CA 94568
Toll Free: (800) 782-0010 • Fax: (925) 833-7301

DISABILITY CERTIFICATION FOR PENSION CREDITS

To be completed by PARTICIPANT Local Union #: ___________________

Name (please print) :____ Social Security No._______-_______-_______

Address: ____ Phone Number: _________________________

City: ____________________________________ State:____________________________ Zip Code _____________

Proof of payment from either State Disability or Workers Compensation must be attached

This is to certify that I: __ **did** receive: __ **State Disability** start date**:** _________________
__ **did not** __**Workman's Compensation** end date: __________________

____ ____
Employee's Signature Date Signed

To be completed by PHYSICIAN

This is to certify that the above-named patient was unable to work at his/her trade from:

______________________________ through ____________________________due to the following disability.
(mm/dd/yyyy) (mm/dd/yyyy)

1) Diagnosis: ____

2) Date of onset of this disability: ____

3) Has patient been previously treated for this illness or injury? □ **YES** □ **NO**

If the answer to #3 is yes, indicate date of first prior treatment:____

4) Is continuing treatment necessary? □ **YES** □ **NO**

5) Date of last treatment: ____

6) Date patient returned to work or anticipated date of return to work: ______________________________________

__________________________________ ______________________ ______________________________
Physician's Name (please print) **License Number** **Phone Number**

Address: ____

City: ____________________________________ **State:** _________________________ **Zip Code:** _______________

Physician's Signature: ____ **Date:** __________________________

PLEASE NOTE: Information requested on this form is to determine eligibility for pension credits. Pension credits may be denied if information is found incomplete and/or false.