Local One

International Union of Elevator Constructors

of New York and New Jersey - (AFL-CIO)

47-24 27th Street, Long Island City, N.Y. 11101

Emergency Relief Fund

TO BE COMPLETED BY MEMBER

A. Complete this section of the form. Sign authorization to release information.
B. Have your Doctor complete the Attending Physician's Statement.
C. Return the FULLY COMPLETED form PROMPTLY so that prompt attention can be given to your claim.

Brother Name and Address (No.) (Street) (City) (State)

Zip Code	Telephone No.	Union Card No.	Compensation Case No.	Social Security Number

Date you last worked	Employed By	Dept.	Position	Person in Charge

Title | If person in charge is a brother give card No.

When did you become continuously disabled (unable to Work?)
Date Time A.M. P.M.

If hospitalized, give name of hospital and address

Dates confined to hospital
From A.M. P.M. To A.M. P.M.

If returned to work, give date | If not, when do you expect to return?

Nature of disability

State when, where and how if occurred

Signed

Date

1. Diagnosis and concurred conditions

2. Is condition due to injury or sickness arising out of patient's employment? YES ☐ NO ☐

3. Report of Services

Date of Services	Place	Description of Surgical or Medical Services Rendered

Place of Services

PH — Patient's Home DO — Doctor's Office OH — Outpatient Hospital
IH — Inpatient Hospital OL — Other Locations NH — Nursing Home

4. Date accident happened | 5. Date patient first consulted you for this condition

6. Patient ever had same or similar condition? YES ☐ NO ☐ | 7. Patient still under your care for this condition YES ☐ NO ☐

8. Patient was continuously totally disable (Unable to work) | 9. If still disabled ,date patient should be able to return to work