Airconditioning
And Refrigeration
Industry Joint Trust Funds
3500 W. Orangewood, CA 92868 • Phone 714-917-6100 Fax 714-917-6067

STATEMENT OF CONTINUANCE OF DISABILITY
DOCTORS STATEMENT

Claimant: _____

SS # last 4 numbers only: _____

This is to certify that I have previously completed the required form for the above claimant in connection with a claim for:

WEEKLY DISABILITY BENEFITS:

from _____ to _____.

Since the claimant was unable to return to work on the above date, extension of time is hereby certified.

The patient has been unable to perform his/her regular or customary work:

from: _____ to _____.

Approximate date Patient might return to work _____.

_____ M.D.
DOCTOR'S NAME

_____
ADDRESS

_____

_____
PHONE

_____ _____
DOCTOR'S SIGNATURE DATE