**Note to Participant**:
**Please return this form with your completed Annuity distribution application**

**Annuity Fund**
**of Local No. One, I.A.T.S.E.**

320 West 46th Street, 6th Floor ● New York, NY 10036 ● Tel (212)247-5225 ● Fax (212)977-9319 ● www.fundoneiatse.com

# Physician Certification of Temporary Disability

Patient Name: _____

Patient Date of Birth: _____

***To be completed by the Physician providing treatment for the condition of disability:***

**Physician Information:**

Name: _____

Telephone: _____

Provider Type / Specialty: _____

License Number: _____

**Patient Disability:**

Nature of Disability : _____

_____

Date patient's disability commenced: _____

Expected date patient will be able to return to work: _____

**Physician's Certification:**

I hereby certify that:

- I am a licensed physician treating the above-named patient for the condition of disability, and
- the above-named patient is unable, as a result of bodily injury or by reason of disease, to engage in any gainful employment for a period of 45 or more days*.

* *Please note that there must be at least 45 days between the date the disability commenced and the date of this certification.*

_____ _____

Physician's Signature Date Signed