Masonry Welfare Trust Fund
9848 E BURNSIDE
PORTLAND OR 97216
(503) 254-4022 (503) 254-4119 FAX
TOLL FREE 1 800 591-8326

DISABILITY WAIVER APPLICATION

There are a total of three (3) Disability Waivers per disability. You must be covered the month the disability occurred to be eligible. Please complete the "Employee" section and have your physician complete the "Physician" Section. Please Promptly return to the address at the left. Refer to page 9 of the benefit booklet dated July 1997 for more information.

Employee Information

Soc. Sec.# _____

Name: _____

Date last worked _____

Have you returned to work _____
If yes, on what date _____

Check One:

This is the first time I'm submitting this form ☐

I am submitting an **update** on my disability ☐

I understand that there are three (3) Disability Waivers available to me per disability and I do Authorize the Trust Office to apply one, or up to three Waivers, if applicable.

_____
Signature of Participant Date

Please have your **physician** complete the bottom portion. Please return to the Trust Office at the above address.

Physician Information

I certify I attended _____ Age _____

Is disabled due to Accident/Injury? _____ or Illness? _____

If INJURY: Brief History: _____

Objective Findings: _____

If ILLNESS: Diagnosis: _____

Date of first medical treatment: _____

Nature of surgical or obstetrical procedure, if any (describe fully): _____

_____

Where performed: _____ Date: _____

The patient has been continuously disabled (unable to work) from: _____ Through: _____

If released to "light duty" what is date released and restrictions: _____

_____

When should patient be able to return to un-restricted work (please estimate if exact date unknown): _____

Remarks: _____

_____

Signature of attending physician: _____ Date: _____

Address: _____

_____ Phone: _____