South Central United Food and Commercial Workers Unions and Employers Health and Welfare Trust

661 N. Ericson Rd., Cordova, TN 38018 • Toll Free: 1·800·874-8499 • Fax: 1·901-758-3021

LOSS OF TIME CONTINUATION FORM

Attending Physicians Office or Kroger Store Management

Employee's Name:	Social Security No.:	DOB	Gender

ADDRESS:	STREET	CITY/STATE	ZIP CODE

Local Union NO:	Your Phone No.: ( )_____-_____

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, dental/mental prepayment plan, employee welfare benefits plan (Including the Trust), service organization, physician, practitioner or other person and hospital;, including Veteran's Administration or other institution, to release or to obtain any medical/dental or benefit payment information that may be required to establish or support the validity of this claim, and further authorize said company, person or organization (including the Trust), in its discretion, to disclose to any other person, company or organization so requesting any of my personal, dental/medical or claim information obtained in any case study or claim review. A photocopy of this authorization shall be as valid as the original.

★ **Employee's Signature:**	**Date of Signature:**

Attending Physician Statement, Disability Continuation (Doctor Completes section below)

First date of treatment for this condition: *(mm/dd/yyyy)* _____/_____/_____	**Most recent** date of treatment for this condition *(mm/dd/yyyy)* _____/_____/_____	*(mm/dd/yyyy)* _____/_____/_____

About your patient's prognosis

- ✓ Diagnosis/ICD-10 Primary Code: _____ Diagnosis/ICD-10 Secondary: _____
- ✓ Have you advised your patient about when they can return to work?
- ✓ ☐ Yes *(Check all that apply.)*
- ✓ ☐ To regular occupation. On date *(mm/dd/yyyy)* _____/_____/_____☐ Full-time ☐ Part-time ☐ Modified duty
- ✓ ☐ To any other occupation. On date *(mm/dd/yyyy)* _____/_____/_____☐ Full-time ☐ Part-time ☐ Modified duty
- ✓ ☐ No *(Please explain.)*_____

Name: (ATTENDING PHYSICIAN)	Phone #:	Degree of Specialty:	
Address:	City/State/Zip	Business/Practice Name:	TIN/EIN/NPI:

AUTHORIZED SIGNATURE OF PHYSICIAN

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

★ **PHYSICIAN SIGNATURE:** **DATE SIGNED:**

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