NATIONAL IAM
BENEFIT TRUST FUND
Better Benefits • Better Life

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PHYSICIAN CERTIFICATION OF DISABILITY

Patient Name: ______________________________

Employee Name: ______________________________

I certify that the above patient is incapable of self-sustaining employment due to the following physical and/or mental handicap:

____
(Diagnosis and concurrent conditions)

____
(Additional comments or clarification)

The above patient has been totally disabled since: ____________________
(Date)

He/she is expected to remain totally disabled until: ____________________
(Date)

Last evaluation: ____________________ **Next evaluation:** ____________________
(Date) (Date)

PLEASE ATTACH A COPY OF THE PATIENT'S MOST RECENT MEDICAL EVALUATION FOR THE DISABLING CONDITION.

Physician Signature: ______________________________
(Name and degree)

Date Signed: ______________________________

Physician Name: ______________________________
(Please Print Full Name)

Physician Address: ______________________________
(Street Address)

____
(City, State, and Zip)

Telephone Number: ______________________________