



DUES MUST BE PAID CURRENT
Benefit is \$20.00/week for a max benefit of 12 weeks

RETURN FORM TO:
BROTHERHOOD OF TEAMSTERS LOCAL UNION NO. 70
 400 Roland Way • Oakland, CA 94621 • 510-569-9317 • Fax 510-569-1906

CERTIFICATE OF ILLNESS/SICK BENEFITS FORM

NAME: _____ SS#: _____

ADDRESS: _____ CITY _____ ZIP _____

EMPLOYER: _____ PHONE: _____ EMAIL: _____

Date of Illness or Injury: _____ Date Last Worked: _____

PHYSICIAN'S PORTION

I hereby certify that member _____ has been ill and under my care
 from _____ to _____, 20____ suffering from _____.

Condition at this time is _____. Was it chronic? _____ Date when patient will be

able to follow his usual vocation? _____ Did he/she, while under your care perform any kind of work?

_____ If so, what _____? In your opinion is he entitled to sick benefits? _____

Is he/she still under your care? _____ **Probable date of recovery** _____ (MM/DD/YY)

Please complete and return to this office by _____.

Physician's Address: _____ Phone: _____

Signature of attending physician _____

LOCAL UNION'S PORTION

APPROVED BY: _____ APPROVED BY: _____ APPROVED BY: _____

Week No.	New Claim	Continuation 1	Continuation 2
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
PAID			
DATE			
CHECK#			