



New England Carpenters Benefit Funds  
Pension Fund  
Connecticut Office

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DOCTOR'S STATEMENT REGARDING DISABILITY

NAME OF PATIENT \_\_\_\_\_

ADDRESS OF PATIENT \_\_\_\_\_

PATIENT'S SS# \_\_\_\_\_

DATE PATIENT FIRST DISABLED \_\_\_\_\_

REASON FOR DISABILITY \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE PATIENT IS ABLE TO RETURN TO WORK \_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
ADDRESS OF PHYSICIAN

\_\_\_\_\_