DELTA
HEALTH SYSTEMS

Northern California General Teamsters Security Fund

Physician's Statement of Disability

All sections of this form must be completed for the request to be processed.

Employee's Name: _____ DHS ID# or SS#: _____

Employee's Address: _____ Phone#: _____

Employer Name: _____ Local Union: _____

Diagnosis: _____

Diagnosis Code(s)/ICD10, please list all that apply: _____

First date off work for this disability period: _____

On the job injury _____ Off the job injury _____ Illness _____ (**Check one)**

Employee is continuously disabled until his/her next appointment on: _____

Employee is released to full duty on: _____ Employee is released to modified duty on: _____.

_____ _____
Physician's Name Date

_____ _____
Physician's Address Physician's Phone#

_____ _____
Physician's Signature Date

PLEASE RETURN THIS FORM TO DELTA HEALTH SYSTEMS, PO BOX 1147, STOCKTON, CA 95201 OR FAX TO 209-474-5402. CONTACT THE BILLING & ELIGIBILITY DEPARTMENT AT 209-948-8483 FOR ASSISTANCE.