

SICK LEAVE REQUEST

International Brotherhood of Boilermakers
Lodge 146



Date: _____

Member Name: _____ Reg #: _____

PHYSICIAN TO COMPLETE THIS SECTION

Physician Name: _____

Diagnosis: _____

To the best of my knowledge the patient listed above is **unable to work** at the Boilermaker profession.

From: _____ (mm/dd/yyyy)

This patient is expected to be able to return to work on: _____ (mm/dd/yyyy)

Physician's stamp or Physician RX Form must appear here:

Physician's Signature

Date (mm/dd/yyyy)

Please note that any costs incurred to complete this form are the responsibility of the patient.

MEMBER TO COMPLETE THIS SECTION

Is your injury/illness a result of your employment? Yes No

Are you receiving Workers Compensation Benefits? Yes No

I understand my monthly dues will be covered by the Union ONLY FOR THE MONTHS INDICATED ON THIS FORM. (Please note that if you are able to work a minimum of (4) four days in a month, that month will not qualify to be paid out.)

Member's Signature

Date (mm/dd/yyyy)