AFL Hotel & Restaurant Workers Trust Fund

(Gentry Pacific Design Center)
560 N. Nimitz Highway, Suite: 209, Honolulu, HI 96817
PHONE: (808) 523-0199● FAX: (808) 537-1074 ● NEIGHBOR ISLANDS DIAL DIRECT: 1 866-772-8989

● Health & Welfare Trust ●Pension Plan ● Training Trust

DISABILITY CERTIFICATION

Name of Member: _____ Social Security #:_____-_____-_____

Address: _____
Street Address City State Zip Code

Telephone: _____

MEMBER'S STATEMENT:

1. My present employer is:

2. Was your disability leave certified by your employer: Yes_____ No ___

_____ _____
Member's Signature Date

DOCTOR'S STATEMENT:

This is to certify that the above named was absent from covered employment as an AFL Hotel & Restaurant Worker, due to disability for or since the period beginning: _____ to _____

Nature of disability is/was: _____

On this date_____ , this AFL Hotel & Restaurant Worker was released by me to return to covered employment.

Physician's Name (Print):_____

Physician's Signature:_____

Physician's Address:_____

_____

Physician's Phone #: _____ ID# _____ Date:_____

NOTE: IN THE EVENT THAT YOU BECOME DISABLED,YOU MUST NOTIFY THE TRUST FUND OFFICE, IN WRITING, IMMEDIATELY OR NO LATERTHAN 60 DAYS AFTER THE ONSET OF DIABILITY TO QUALIFY FOR DISABILITY CREDITS.