

ACCIDENT AND SICKNESS WEEKLY BENEFITS

LION OIL COMPANY
EL DORADO, ARKANSAS

TO BE COMPLETED BY EMPLOYEE
(All items must be completed)

Employee's name _____ Phone No. _____

Present address _____

Date you were first disabled by this sickness or injury _____

If an accident was involved, answer the following:

When did the accident happen? Date _____ at _____ A.M.
P.M.

Were you at work when the accident happened? _____

Give a brief description of the accident, and where it happened:

When did you report to your Supervisor that you were disabled?

DATE _____ TIME _____ A.M.
P.M.

TO WHOM DID YOU REPORT? _____

WAS THE ILLNESS OR INJURY REPORTED THE FIRST DAY OF YOUR DISABILITY?

IF NOT, WHY? _____

WHEN DID YOU FIRST SEE THE DOCTOR ABOUT THIS ILLNESS OR INJURY? _____

WHO IS YOUR ATTENDING PHYSICIAN? _____

DATE _____

SIGNED _____
Employee

ATTENDING PHYSICIAN'S STATEMENT

LION OIL EMPLOYEES ARE COMPENSATED 100% SICK PAY DURING DISABILITY AFTER A ONE-OR TWO-DAY WAITING PERIOD. THE COST OF THIS IS BORNE BY THE COMPANY AND NOT THE EMPLOYEE.

Patient's name _____ Age _____

Nature of sickness or injury (Describe complications, if any) _____

Did this sickness or injury arise out of patient's employment?

Yes _____ No _____ If "Yes," explain _____

Nature of surgical or obstetrical procedure, if any (Describe fully)

Date performed _____ 20____

Give dates of treatments: Office _____
 Home _____
 Hospital _____

Patient has been continuously disabled (unable to work) from _____
through _____ 20____

If still disabled, when should patient be able to return to work?
_____ 20____

Is patient confined? _____

Date _____ 20____

Signed _____
 Attending Physician

Address _____

Remarks _____