

ILA EMPLOYERS WELFARE FUND

510 West Bryan Street
 Post Office Box 1280
 Savannah, Georgia 31498-1280

DATE _____

TO WHOM IT MAY CONCERN:

This is to certify that _____,
Name of Employee

Social Security # _____, was injured on _____
Employee's SS# Date

while working for _____ to the extent of drawing
Name of Company

Workers' Compensation as follows:

TYPE OF DISABILITY	FROM	TO	NUMBER OF DAYS/ WEEKS PAID

This is to further certify that:

The above employee is still disabled

or

The above employee was released to return to work on _____
Date

 Name of Insurance Company

By: _____
 Signature

Title: _____