•• PROTECTED 関係者外秘

TOYOTA MOTOR MANUFACTURING, Kentucky, INC.
REQUEST FOR BENEVOLENT FUND PAYMENT
MEDICAL INFORMATION

(To be completed by physician, only if you checked Catastrophic Illness on the Benevolent Fund Payment Form.)

EMPLOYEE INFORMATION (Please print)
(to be completed by TMAA member)

Team Member Name: _____

Address: _____

_____

Home Phone: _____

I hereby authorize the physician specified below to release such information as needed by TMAA in connection with this request.

Team Member Signature: _____ Date: _____

MEDICAL INFORMATION (Please print)
(to be completed by attending physician)

Patient name: _____

Diagnosis & current condition of patient: _____

_____

_____

_____

_____

_____

Date condition was determined: _____

Dates & locations of treatments: _____

_____

_____

_____

_____

Give dates of illness/accident: From _____ To _____

Physician's Name: _____ Address: _____

_____

Phone #: _____

Physician's Signature: _____ Date: _____

TMAA REVIEW / APPROVAL

Received by: _____ Date: _____

RETURN COMPLETED FORM (ALONG WITH RECEIPTS) TO TMAA, Human Resources