Northwest Carpenters Health and Security Trust
PO Box 1929, Seattle, WA 98111-1929 | (800) 552-0635 | www.CarpentersBenefits.org

Time Loss Update – Employed Carpenters

1. You (the carpenter) must complete **Section 1 – Carpenter's Statement of Disability** in its entirety, sign and date it, and then forward it to your attending physician.
2. Your attending physician must complete **Section 2 – Attending Physician's Statement of Disability** in its entirety and then sign and date it. You or your physician must return the completed form to Northwest Carpenters Trusts.

Section 1 – Carpenter's Statement of Disability

1. Name (please print):___________________________ Social Security number: ____________________
2. Date of birth:______________________________ Telephone: (______) ________________________
3. Have you been released for or returned to work? ☐ Yes ☐ No If yes, on what date were you released to return to work? If no, when will your physician release you to return to work? ________________________________

Carpenter's Authorization to Release Confidential Information

I hereby certify that the foregoing statements (including any accompanying statements) are true, correct and complete to the best of my knowledge. I further request and authorize my attending physician to release to this plan all facts, records and other information pertaining to my diagnosis, care and treatment. I understand that these records may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol abuse, mental illness, or psychiatric treatment. No further disclosure of the requested information will be made in accordance with Federal Law 42 CRF, Part 2. A photostatic copy of this authorization shall be considered as effective and valid as the original.

____ ___________________________________

Carpenter's signature Date signed

Section 2 – Attending Physician's Statement of Disability

1. Diagnosis: ____
2. Prognosis: ____
3. Date of most recent visit: Month __________________ Day ________ 20 ____
4. Frequency of treatments: ☐ Weekly ☐ Monthly ☐ Other (please specify): _________________________
5. Has the patient been complying with the plan of treatment? ☐ Yes ☐ No. If no, please explain: ___________

   ____

6. This patient has been continuously disabled (unable to work) from (date) ____________ to (date) _____________

7. When did or when should your patient be able to return to work? ____

   If unknown, when is patient's next appointment? ____

8. Have you placed any physical restrictions on this patient? ☐ Yes ☐ No. If yes, please explain: ______________

   ____

   ____

9. Physician's Name (please print):____

10. Address: ____
    (Street) (City) (State) (Zip)

11. Medical Degree and Specialty:______________________________ Telephone: (_____) ___________________

____ ______________________________

Physician's signature Date