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

Application for Time Loss Benefits – Mental Health Disability

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): ____________________
   (First) (MI) (Last)
2. Address: ____________________
   (Street) (City) (State) (Zip)
3. Telephone: ( ) ____________ Social Security Number: ____________
4. Date of Birth: ____________ Employer: ____________
5. Occupation (please be specific): ____________
6. When did you last work? Month ________ Day ______ 20 ______
7. When did you become disabled? Month ________ Day ______ 20 ______
8. Describe your disability: ____________
9. When did you first seek medical attention? Month ________ Day ______ 20 ______
10. Where were you first treated? ____________
11. Is your disability the result of a work-incurred injury or illness? ☐ Yes ☐ No
12. Have you returned to work? ☐ Yes ☐ No. If yes, when? ____________
13. Are you eligible for a wage continuation program (i.e., sick leave)? ☐ Yes ☐ No
14. Have you applied for or been granted a Social Security disability award? ☐ Yes ☐ No

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 Mental Health Disability

History – Symptoms – Plan of Treatment

1. Diagnosis (DSM-IV diagnostic code or provisional diagnosis): ____________
2. Date symptoms occurred: Month ________ Day ______ 20 ______
3. Date of first treatment: Month ________ Day ______ 20 ______
4. Date of last visit: Month ________ Day ______ 20 ______

5. Frequency of treatments: ☐ Weekly ☐ Monthly ☐ Other

6. Date disability commenced: Month __________________ Day __________ 20 _________

7. Number of treatments (visits) since initiation of treatment: ____

8. Is treatment a result of a court order? ☐ Yes ☐ No

9. Has patient had the same or a similar condition before? ☐ Yes ☐ No. If yes, please state when and describe:

   ____

   Past history/symptoms: ____

   Current history and/or disability symptoms: ____

10. Describe which symptoms have changed or improved with this patient since you began treatment (i.e., coping skills, relationship roles, new capabilities)?

    ____

11. What makes continued treatment medically necessary? What is the anticipated termination date of treatment?

    ____

12. List current medications and dosage including any changes or complications: ______________________________

    ____

Extent of Disability

1. As of this date, is the patient totally disabled (meaning incapable of performing any and every duty pertinent to his or her occupation as a carpenter, and not engaged in any other occupation for wage or profit?
   ☐ Yes ☐ No. If yes, what *specific* job duties is patient capable or incapable of performing?

   ____

2. When did or when should the patient be able to return to work? ____

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

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

   ____

Physician Information

1. Physician's name (please print):____

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

3. Medical degree and specialty: ______________________________ Telephone: (_____) ____________________

____ ______________________________

Physician's signature Date signed