Northwest Carpenters Health and Security Trust
PO Box 1929, Seattle, WA 98111-1929 | (800) 552-0635 | Fax (206) 441-5839

Injury Questionnaire

Please provide the requested information and return the signed form to our office as soon as possible. If someone else is responsible for the injury, please also complete and return a signed Reimbursement Agreement form. Call (800) 552-0635 to request a form by mail.

Participant's name _____

Participant's Member Number _____

Patient's name _____

1. Type of injury _____

2. Date, time, and place of injury _____

3. How did the injury occur? _____

4. Who was responsible for the injury? _____

5. Is this illness or injury work related? ☐ Yes ☐ No. If yes, please provide the worker's compensation claim number. _____

6. If this claim is not the result of an injury, please explain the onset of the illness.

_____

_____

I hereby certify that the foregoing statements are true, correct, and complete to the best of my knowledge.

_____ _____

Participant's signature Date signed