Northwest Carpenters Health and Security Plan

PO Box 1929 Seattle, WA 98111-1929

Self-Contribution Certificate of Disability

Instructions

1. You (the carpenter) must complete **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 **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 as soon as possible.

Carpenter's Statement of Disability

1. Name (please print): _____
   (First) (MI) (Last)
2. Mailing address: _____
   (Street) (City) (State) (Zip)
3. Telephone: ( ) _____ ☐ Mobile ☐ Land Social Security #: _____
4. Date of Birth: _____ Employer: _____
5. Describe your disability: _____

   _____
6. Are you engaged in any other occupation for wage or profit? ☐ Yes ☐ No
7. Are you receiving unemployment compensation? ☐ Yes ☐ No

Authorization To Release Confidential Information – Carpenter

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 _____

Please See Reverse Side for Attending Physician's Statement of Disability

Attending Physician's Statement of Disability

Extent of Disability

1. Diagnosis: _____
2. As of this date, is the patient disabled (incapable of performing any and every duty pertinent to his or her occupation as a carpenter)? ☐ Yes ☐ No. If yes, is the disability temporary or permanent? _____
3. When should your patient be able to return to work? _____
   If unknown, when is your patient's next appointment? _____
4. Have you placed any physical restrictions on this patient? ☐ Yes ☐ No. If yes, please explain: _____

   _____

Physician Information

1. Physician's Name (please print): _____
   (First) (MI) (Last)
2. Address: _____
   (Street) (City) (State) (Zip)
3. Telephone: ( ) _____
4. Medical Degree and Specialty: _____

Physician's Signature: _____ Date: _____