Carpenters Health and Security Trust of Western Washington

PO Box 1929 Seattle, Washington 98111 Phone: (206) 441-6514 Fax: (206) 441-5839

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 Carpenters Trusts as soon as possible.

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? _____

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: _____

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
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: _____ to _____
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: ( ) _____
12. Physician's Signature: _____ Date: _____