Carpenters Health and Security Trust of Western Washington
PO Box 1929 Seattle, Washington 98111 Phone: (206) 441-6514 Fax: (206) 441-5839

Time Loss Benefits For Mental Health Disability – 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): _____ (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

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: _____

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 _____

See Reverse Side For Continuation of Attending Physician's Statement of Mental Health Disability

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: ( ) _____
4. Physician's Signature: _____ Date: _____