Carpenters Retirement Plan of Western Washington

PO Box 1929 Seattle, Washington 98111 (206) 441-6514

Disability Retirement Questionnaire – Two-Year Follow-Up

Instructions

- You (the carpenter) must complete **Section 1 (pages 1-2) – Carpenter's Statement of Disability** in its entirety, sign and date it and then forward it to your physician.
- Your physician must complete **Section 2 (pages 3-4) – 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 the Trust Office as soon as possible.

Section 1 – Carpenter's Statement of Disability

1. Name (please print): _____

2. Social Security number: _____ Date of birth: _____

3. Occupation prior to disability (please be specific): _____

   _____

4. Describe your current disability: _____

   _____

   _____

5. Please list the name, address and telephone number of the physician you are currently seeing for this disability:

   _____

   _____

6. Are you currently engaged in any rehabilitation? ☐ Yes ☐ No. If yes, please specify type of rehabilitation and the period of time in the program: _____

   _____

   _____

7. Have you applied for or been granted a Social Security Disability award? ☐ Yes ☐ No. If yes, please provide the Trust with a copy of your Social Security award letter.

8. Have you been granted Medicare benefits? ☐ Yes ☐ No

9. Have you been engaged in any gainful employment since you were disabled? ☐ Yes ☐ No. If yes, please answer questions (a) – (c):

   (a) Are you presently employed in a full- or part-time position? ☐ Yes ☐ No. If yes, please describe your employment arrangement, job classification, name of employer and length of employment.

   _____

   _____

(b) List other crafts, trades and professions you have been employed in and the duties that you performed in each:

_____

_____

_____

(c) Are you presently attending school or being retrained for another job classification? ☐ Yes ☐ No. If yes, please complete the following:

Name of school: _____

Course of study or major: _____

Date expected to complete schooling or training: _____

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 for this disability. 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

Instructions

- The carpenter must complete **Section 1 (pages 1-2) – Carpenter's Statement of Disability** in its entirety, sign and date it and then forward it to his or her physician.
- You (the carpenter's physician) must complete **Section 2 (pages 3-4) – Attending Physician's Statement of Disability** in its entirety and then sign and date it. You or the carpenter must return the completed form to the Trust Office as soon as possible.

Present Condition:

1. Subjective findings: _____
2. Objective findings: _____
3. Diagnosis: _____
4. Pertinent diagnostic findings (x-rays, laboratory and others): _____

Extent of Disability:

1. As of this date, is your 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 no, what *specific* job duties is patient capable or incapable of performing? _____
2. When did or when should your patient be able to return to work? _____
   If unknown, when is patient's next appointment? _____
3. Have you placed any physical restrictions on this patient? ☐ Yes ☐ No. If yes, please explain: _____
4. Date of last visit: Month _____ Day _____ 20 _____
5. Frequency of treatments: Weekly ____ Monthly ____ Other _____

Physician's Statement of Disability:

Total and permanent disability, for the purposes of the Carpenters Retirement Plan of Western Washington means the disability or bodily injury or disease which, on the basis of medical evidence, can be assumed to be permanent and

continuous during the reminder of the patient's lifetime and renders the patient incapable of performing any and every duty pertinent to his or her occupation.

I hereby certify that I have examined this patient and conclude that the patient (please do not send chart notes, x-rays, etc.):

❑ **IS**

❑ **IS NOT**

permanently disabled as described in the paragraph above. Please feel free to provide any additional information which will assist the Board of Trustees in making an informed decision about your patient's disability.

_____

_____

_____

_____

Physician Information:

1. Physician's name (please print):_____
2. Address: _____
3. Medical degree and specialty: _____ Telephone: ( ) _____
4. Physician's Signature:_____ Date:_____