

Carpenters Health and Security Plan of Western Washington  
Injury Questionnaire

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 this illness: \_\_\_\_\_  
\_\_\_\_\_

Please note: If someone else is responsible for the injury (a third party), please complete a "Trust's Right to Reimbursement" form in addition to this questionnaire. Contact the Trust Office for assistance.

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

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_