

Carpenters Health and Security Plan of Western Washington

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

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 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 CFR, 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: _____