THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE FUND
Application - Temporary Total Disability

Return completed form to:
The Employee Painters' Trust
PO Box 58830
Tukwila, WA 98138

Trust Fund Phone #: (206) 518-9730
Toll Free #: (844) 344-2721
Fax #: (425) 251-1976

PART I – EMPLOYEE TO COMPLETE IN FULL

(Please attach copies of 2 recent paystubs and all related medical records.)

Name: _____ **Birth date:** _____ **SSN:** _____

Street: _____ **E-mail Address:** _____

City and State: _____ **Zip:** _____ **Member's Phone:** _____

Description of Disability: _____ **Injury?** _____ **Illness?** _____

Are you receiving any other compensation from other sources during any portion of your disability? (circle) YES / NO. If Yes, please provide additional information below:

State FMLA Compensation Source (State/Agency Name): _____ **Amount:** _____ **Date:** _____
Disability Insurance Source (Insurer Name): _____ **Amount:** _____ **Date:** _____
Other FMLA/Vacation/Sick/PTO Pay Source: _____ **Amount:** _____ **Date:** _____
Other Compensation Source: _____ **Amount:** _____ **Date:** _____

Date of Injury/Illness: _____ **Time:** _____ **At Work?** _____ **At Home?** _____

How did it happen? _____

Job Description: _____

Last full day of work prior to disability: _____

I hereby Authorize my Providers by this form (or by photocopy) to RELEASE ANY RECORDS you have regarding my disability to Employee Painters' Trust Fund and/or Innovative Care Management. I certify the above answers are true and complete to the best of my knowledge and belief.

Date: _____ **PATIENT SIGNATURE:** _____
Signature Only - Do Not Print

PART II – EMPLOYER STATEMENT

1. Was this illness or injury caused by the employee's employment? YES / NO
2. Is the employee currently receiving compensation while unable to work? YES / NO

If "Yes" explain the following:

Compensation effective date: _____ **Frequency of the compensation:** _____

Amount of compensation: _____ **Who the compensation is paid by (Employer/State/Agency Name):** _____

Date: _____ **Employer Signature:** _____

Employer Phone Number: _____ **Employer Name:** _____

PART III – PHYSICIAN'S STATEMENT

Per the release signed above, PLEASE ATTACH ALL CLINICAL RECORDS applicable to substantiate disability. Including but not limited to: Office Visit Chart Notes, History & Physical Chart Notes, Imaging/X-Ray Reports, Lab Test Results, Pre-operative Visit Notes/Test Results, Operative Reports, Post-Operative Visit Notes/Test Results, etc.

1. **Nature of illness or injury/ICD9 (Describe complications if any):** _____
_____ **Illness?** _____ **Injury?** _____

2. Was this illness or injury caused by patient's employment: YES / NO Was it aggravated by Patient's employment? YES / NO

If "Yes" please explain: _____

3. Nature of surgical procedure, if any/CPT (Describe fully) _____

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4. Date Surgery Performed: _____ **Was Patient Hospitalized: Admission Date**: _____

Discharge Date: _____

5. Give Dates of Treatments:

FIRST CONSULATION — OTHER OFFICE VISITS DURING THIS PERIOD OF DISABILITY

Office _____ _____

Hospital _____ _____

6. The patient has been continuously disabled (unable to work): From: _____

Through (approximate date is ok): _____

Additional Comments: _____

Date _____ **Physician's Name (Print)** _____ **Degree** _____

Physician's Signature _____

Address _____

Physician's Phone Number: _____ **Physician's Fax Number:** _____

Revised 06/23/2025