SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST

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Short Term Disability – Time Loss and Premium Waiver

Part 1 – To be completed by PARTICIPANT (Each question must be fully answered)

1. Name: _____ 2. Birth Date: _____ SSN: _____

Address: _____ 3. Last day worked prior to disability: _____

City/State: _____ Zip code: _____ Phone#: _____

4. My disability is: _____ Injury? ☐ Illness? ☐

5. Date and time it happened: _____ At work? ☐ At home? ☐

6. How did it happen? _____

7. Job Description/Classification: _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give the Seattle Area Plumbing and Pipefitting Industry Health Trust any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

_____ _____

PARTICIPANT SIGNATURE – *Please Do Not Print* **Date**

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any): _____

_____

2. Was this sickness or injury caused by patient's employment? Yes ☐ No ☐

Illness? ☐ Injury? ☐

Was it aggravated by Patient's employment? If "Yes" explain. _____

_____

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

_____

4. Date performed: _____

5. Give dates of treatments:

	FIRST CONSULATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office	_____	_____
Hospital	_____	_____

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

From: _____ To: _____
(if unsure give tentative date)

If still disabled, when should patient be able to return to work? _____

7. Remarks _____

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

Physician's Signature: _____

Address: _____

Physician's Phone Number: _____