



Return this Form to:
OREGON-WASHINGTON CARPENTERS-EMPLOYERS TRUST
 c/o WILLIAM C. EARHART CO., INC.
 P.O. BOX 4148 - PORTLAND, OREGON 97208
 PHONE: 503/282-5581 • WATS 1-800-547-1314 • FAX 503/460-2975
STATEMENT OF SHORT TERM DISABILITY CLAIM

**DO NOT ATTACH
 MEDICAL BILLS**

| | | | | | | | |
|--|---|-------------------------------------|--|--------------------------|--|---|--|
| PART 1 INSURED MEMBER COMPLETES | EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL) | | EMPLOYER NAME (OR COMPANY YOU WORK FOR) | | | | |
| | ADDRESS | | | DATE EMPLOYED | EMPLOYEE'S DATE OF BIRTH | | |
| | CITY, STATE | | ZIP CODE | SOCIAL SECURITY NO. | LOCAL UNION NO. | HOME TELEPHONE NO. | |
| | 1. NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM (INCLUDING AUTOMOBILE INSURANCE AND WORKMEN'S COMPENSATION). | | | | | | |
| | 2. DID PATIENT'S WORK CAUSE THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO | | HAS A CLAIM BEEN FILED WITH THE WORKMEN'S COMPENSATION CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO | | WAS PATIENT AT WORK WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FOR WHOM? | | |
| | IF CLAIM IS FOR AN INJURY COMPLETE THIS SECTION | DATE OF INJURY | TIME | FIRST DAY UNABLE TO WORK | | IF YOU HAVE RETURNED TO WORK GIVE DATE OF RETURN. | |
| | | HOW DID INJURY HAPPEN? | | | | | |
| | | WHERE WAS THE PATIENT WHEN INJURED? | | | | | |
| | "I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OR SERVICES, OR ANY ORGANIZATION IN POSSESSION OF INSURANCE OR BENEFIT INFORMATION, TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME OR MY DEPENDENTS. | | | | | | |
| | EMPLOYEE'S SIGNATURE X | | | | SIGN HERE | DATE SIGNED | |

| | | | | | |
|---|---|----------------------|---|--|----------------------------------|
| PART 2 ATTENDING PHYSICIAN'S STATEMENT | PHYSICIAN'S STATEMENT OF SHORT TERM DISABILITY | | | | |
| | 1. PATIENT'S NAME | | AGE | ADDRESS | |
| | 2. DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.A.) | | | NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY (Describe Fully) | |
| | 3. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF EMPLOYMENT? <input type="checkbox"/> < YES NO > <input type="checkbox"/> | | 4. IS CONDITION DUE TO PREGNANCY? <input type="checkbox"/> < YES NO > <input type="checkbox"/> | | APPROX. DATE PREGNANCY COMMENCED |
| | 5. HAS A CLAIM BEEN FILED WITH A WORKER'S COMPENSATION CARRIER? IF YES, PLEASE IDENTIFY <input type="checkbox"/> < YES NO > <input type="checkbox"/> | | | | |
| | 6. GIVE DATES OF TREATMENTS | OFFICE | | | |
| | | HOME | | | |
| | | HOSPITAL (ADMISSION) | | (DISCHARGE) | |
| | 7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> NO <input type="checkbox"/> YES | | | | |
| | 8. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED | | | 9. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION | |
| 10. PATIENT WAS COMPLETELY UNABLE TO WORK DUE TO INJURY OR SICKNESS <input type="checkbox"/> < YES NO > <input type="checkbox"/> FROM THRU | | | 11. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK. | | |
| DESCRIBE COMPLICATIONS, IF ANY, PRECLUDING PATIENT FROM RETURNING TO REGULAR OCCUPATION | | | | | |
| Date | Print or type Physician's name & degree | | | Signature (Attending Physician) | |
| Street address | | City or Town | State | Zip Code | Telephone |

| | | | | | |
|-----------------------------------|---|---------------|-------------------------------|-------------------|------------------------------|
| PART 3 EMPLOYER'S STATEMENT | EMPLOYER MUST CERTIFY FOR SHORT TERM DISABILITY | | | | |
| | DATE EMPLOYED | WEEKLY SALARY | FIRST FULL DAY UNABLE TO WORK | DATE RESUMED WORK | DATE EXPECTED TO RESUME WORK |
| | IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? <input type="checkbox"/> < YES NO > <input type="checkbox"/> | | | | |
| | Company Name _____ | | | | |
| | Mailing Address _____ | | Telephone _____ | | |
| STREET | | CITY | STATE | ZIP | (AREA CODE) NUMBER |
| Dated _____ 20____ By _____ | | Title _____ | | | |