WHITMAN COUNTY LEOFF I BOARD
LEOFF I MEMBER
DISABILITY APPLICATION
LIST OF HEALTH CARE PROVIDERS

Please list the physicians and therapists who have treated you regarding the condition for which you are filing for disability benefits:

Employee' Name: ______________________________ SSN#: ______________________________
Health Care Provider: ______________________________ Date treatment began: ______________________________
Address: ______________________________ Phone: ______________________________
Diagnosis: ______________________________ Treatment provided: ______________________________

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Employee' Name: ______________________________ SSN#: ______________________________
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Address: ______________________________ Phone: ______________________________
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___ Additional sheet attached.

I hereby authorize my health care provider, at my cost, to supply the LEOFF I Board with any information they may request regarding my disability. My consent is given only for the purpose of establishing my right to disability benefits.

Employee's Signature: ______________________________ Date: ______________________________

WCLIB #3