BEFORE THE KENNEWICK DISABILITY BOARD

APPLICATION FOR DISABILITY LEAVE/RETIREMENT

Name_____ SS#_____

Address_____

_____ Zip_____

Sex_____ Date of Birth_____ Phone ( )_____

Name of Employer_____ Date Hired_____

Rank and Position_____

I hereby apply for disability benefits effective _____
according to the provisions of ___ RCW 41.26.120 (duty incurred)
or ___ RCW 41.26.125 (non-duty incurred). My last day of service was or will be _____.

The nature of this disability is:_____

_____

_____

This disability [ ]was, [ ]was not incurred in the line of duty.

This disability [ ]was, [ ]was not incurred while in other employment.

This is a [ ]physical, [ ]mental, [ ]physical and mental disability.

I hereby submit _____ statement(s) by my physician(s) regarding my disability and authorize my physician(s) to supply you with any information which you may request. I also consent to examination by your board appointed physician or board approved specialist. I understand that my consent is given only for the purpose of establishing my right to disability benefits.

The information contained herein is true and complete to the best of my knowledge and belief.

_____ _____

Signature Date

AFFIDAVIT

STATE OF WASHINGTON)
) ss
County of Benton)

I, _____, being first duly sworn on oath do hereby declare that I am a member of the City of Kennewick _____ Department and that on the_____ day of _____, 19_____, I was disabled by reason of _____

_____

_____

_____

_____.

_____
(Member's Signature)

Subscribed and sworn to before me this _____ day of _____, 19_____.

_____
Notary Public in and for the State of Washington

residing at _____.

My commission expires _____.

PART I - EMPLOYER'S STATEMENT

REPORT OF INJURY

1. Name of injured employee:_____

2. Social Security Number:_____

3. Will this employee be kept on salary during the period of disability? _____

4. Date and hour of injury:_____AM / PM

   Last day worked:_____ Date returned to work:_____

5. Was employee engaged in regular course of employment when injury occurred? _____

6. Date and hour injury was reported to you:_____AM / PM

7. Attending physician: Name _____

   Address _____

8. Location or place where injury occurred:_____

   _____

9. How did the injury happen:_____

   _____

   _____

10. Do you question allowance of the claim? _____ If so, why? _____

    _____

    _____

I declare that the foregoing statements are true to the best of my knowledge and belief.

Signed this _____ day of _____, 19____.

_____ _____

Employer Official Position

PART II - EMPLOYEE'S STATEMENT

REPORT OF DISABILITY

Employee:_____ Social Security Number:_____

Address:_____

Birthplace:_____ Birthdate:_____ Age:_____ Ht:_____ Wt:_____

Name of spouse (if married)_____

If divorced, give final decree date_____

Name of Employer: CITY OF KENNEWICK Department:_____ Position:_____

Date of disability:_____ Time:_____ Shift hours:_____

Date employed:_____ Date last worked:_____ Date returned to work:_____

Were you doing your regular work at the time of disability?_____

Location where disability occurred:_____

Date disability reported to employer:_____

To whom was it reported?_____ Title:_____

Describe in full how the disability occurred:_____

_____

Were there any witnesses?_____ If so, who?_____

Attending physician: Name:_____

Address:_____

Phone:_____

I hereby authorize the Kennewick Disability Board to obtain such medical information as may be required for approval of this claim.

Signed this _____ day of _____, 19____.

_____

Employee

PART III - PHYSICIAN'S STATEMENT

REPORT OF DISABILITY

Injured Employee:_____ Position:_____

Social Security No:_____Address:_____

Date of disability:_____Date of first treatment:_____

History of disability (How did it occur?):_____

_____

Is condition a result of an accident?_____Please exlain:_____

_____

Physical findings in detail:_____

Diagnosis:_____

X-Ray findings_____

Treatment prescribed:_____

Has employee ever been treated by anyone for present or similar condition? _____

If so, by whom and when? _____

Is there any pre-existing disease of the injured area?_____

Will this or any pre-existing condition complicate treatment:_____

Estimated time loss due to injury:_____

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

Signed this _____ day of _____, 19_____.

_____ _____

Print physician's name Signature of attending physician

Complelte and return to:
Kennewick Disability Board
P. O. Box 6108
Kennewick, WA 99336