

**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: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

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Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

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SSN#: \_\_\_\_\_  
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SSN#: \_\_\_\_\_  
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Employee' Name: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

SSN#: \_\_\_\_\_  
Date treatment began: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_

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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: \_\_\_\_\_