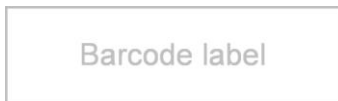


Statement of Health, Education, and Employment

A. CLIENT INFORMATION			
CLIENT'S NAME	CLIENT'S TELEPHONE NUMBER	CLIENT ID NUMBER	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE	SOCIAL SECURITY NUMBER	
Have you applied for or received any of the following: <input type="checkbox"/> Labor and Industries/Worker's Compensation <input type="checkbox"/> Social Security Disability or SSI <input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Veteran's Benefits (VA)			WHEN?
B. HEALTH INFORMATION			
1. Are you unable to work because of a health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information: 2. List the health problems you have now: 3. Have you been treated for this health problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, tell us where and when you received treatment:			
CLINIC/HOSPITAL	DOCTOR'S NAME	DATES	PHONE/FAX
4. Does this problem keep you from working now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, tell us why: 5. Have you lost a job because of this health problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, tell us what happened: 6. What kind of help or services do you need in order to return to work?			



C. EDUCATION AND TRAINING

1. What is your primary language? _____ Can you read and write in English? Yes No
2. Are you left-handed or right-handed? Left-handed Right-handed
3. What is the highest grade you completed in school (K – 12): _____
4. High school diploma? Yes No GED? Yes No
5. Did you attend special education classes? Yes No

NAME OF SPECIAL EDUCATION CLASS	GRADE LEVEL	REASON FOR SPECIAL EDUCATION CLASSES		SCHOOL LOCATION OR DISTRICT
TYPE OF TRAINING	DATES	COMPLETED		CERTIFICATE LICENSE OR DEGREE AND YEAR
		YES	NO	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

D. WORK HISTORY

1. What do you consider your usual occupation? _____

2. List your last three (3) jobs beginning with the most recent job (include jobs listed in B, if appropriate):

MOST RECENT JOB TITLE	EMPLOYER'S NAME	HOURS PER WEEK	MONTH AND YEAR START: STOP:	WHY DID YOU STOP WORKING?

Tell us about what you did at this job:

SECOND JOB TITLE	EMPLOYER'S NAME	HOURS PER WEEK	MONTH AND YEAR START: STOP:	WHY DID YOU STOP WORKING?

Tell us about what you did at this job:

THIRD JOB TITLE	EMPLOYER'S NAME	HOURS PER WEEK	MONTH AND YEAR START: STOP:	WHY DID YOU STOP WORKING?

Tell us about what you did at this job:

3. What other type of work have you done in the last five (5) years?

4. What work skills do you have? Include any hobbies such as sewing, wood working, repairing cars.

IF SOMEONE TRANSLATED OR HELPED YOU FILL OUT THIS FORM, ENTER THEIR NAME AND RELATIONSHIP TO YOU HERE

I declare under penalties of perjury that the information given by me on this Statement of Education, Employment, and Health is true, correct, and complete to the best of my knowledge. I understand that the Department of Social and Health Services may require me to provide proof of my statements.

CLIENT'S SIGNATURE	DATE
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