Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

APPLICATION FOR L.E.P. COMPENSATION MED

Unit	Work Position
Claim Number	
Date Requested	
Date of Injury	

How to apply: 1) Complete and sign the worker section of this form 2) Have your employer and attending physician complete their sections. 3) Mail this paperwork to the above address. Questions? Contact your claim manager.

Worker's Section

At the time of injury, I was working: _____ hours per day _____ days per week.
I am currently working: _____ hours per day _____ days per week.
My gross earnings, before deductions, for the work period: _____to _____ were $_____
On the date of your injury, was your employer paying any part of your and/or your family's medical, dental and/or vision insurance benefits, or providing housing, board and/or fuel (utilities)? ☐ Yes ☐ No
Are you still receiving these benefits? ☐ Yes ☐ No Date coverage ended _____
During this work period, my current employer is/was paying for my medical, vision, or dental benefits ☐ Yes ☐ No

By signing below, I am certifying the following: **I understand that if I make a false statement about my activities or physical condition, I will be required to refund my benefits and I may face civil or criminal penalties. I understand I must report on this form any work performed (paid or unpaid), if my doctor releases me for full duty, if I am incarcerated and under sentence, or if the custody of my children changes**.

Date	Worker's signature

Employer's Section

To be completed by employer or a copy of your payroll record for the above period can be attached.

Wages were paid for the period _____ to _____ Gross Wage paid $_____
During this period: # work hours available _____ # hours worked _____
Were vacation wages paid during this period? ☐ No ☐ Yes Amount paid $_____
Were sick leave wages paid during this period? ☐ No ☐ Yes Amount paid $_____
Were holiday wages paid during this period? ☐ No ☐ Yes Amount paid $_____
Are you currently contributing to the worker and/or worker's family medical, dental and/or vision benefits, or providing housing, board and/or fuel (utilities)? ☐ No Date ended _____
☐ Yes Amount of contribution $_____ Please check if your contribution was by the ☐ Hour ☐ Day ☐ Week ☐ Month

Name of employer	Phone Number

Date	**I certify that the earnings shown above are correct, according to our records**. Employer's signature _____ Title _____

Physician's Section

Diagnosis due to workplace injury or illness**:** _____

The present disability allows the worker to perform only ☐ Modified/lighter duty
☐ Reduced hours # hours per day _____ # days per week_____
List and explain physical restrictions: _____

Have you advised the worker to return to pre-injury work schedule or pre-injury duties? ☐ No ☐ Yes, on _____	If No, when do you anticipate the worker will be able to return to pre-injury work schedule or pre-injury duties? _____

Are there factors impeding recovery, such as unrelated medical conditions, socio-economic or chemical dependency? ☐ Yes ☐ No
If yes, explain and use additional sheets if needed.
Has the worker's condition, due to this injury, reached maximum medical improvement? ☐ Yes ☐ No
Will permanent impairment result from this injury? ☐ Yes ☐ No ☐ Undetermined
Comments:

Phone #	Date	Physician's signature