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



APPLICATION FOR L.E.P. COMPENSATION VOC

					Unit	WORK POSITION
					Claim Numbe	PT
					Date Requeste	ed
					Date of Injury	7
				section employ 3) Mail	of this form. 2) Ter and vocationa	lete and sign this Take form to your Il counselor to complete. to the above address. claim manager.
Worker's Sectio	n					
At the time of injur			days per w	veek.		
I am currently work	_	hours per day _			<i>*</i>	
		ns, for the work period:				
•		employer paying any part of sing, board and/or fuel (utility		-	's medical, dent	al and/or vision
Are you still receiv	-	,			Data agraras	e ended
-					_	
		employer is/was paying for i				
will be required to re	fund my benefits a	owing: I understand that if I is not I may face civil or criminal or releases me for full duty, if I	l penalties. I unde	erstand I	must report on t	his form any work
Date	Work	ter's signature				
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Date Employer's S Wages were paid for	ection To be or the period	completed by employer or a o	Gross		d for the above p	
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