

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
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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
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