



REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

Claim # **AG 38845**

Language Preference (circle one)
English Spanish Russian Korean Chinese Vietnamese Laotian Cambodian Other:

| | | | | | | | | | |
|---|--|--|-----------------------------------|---|--|--|--|--|--|
| 1. Name (First-Middle-Last) | | 2. Sex (circle one) Male Female | | 14. Date of Injury or Last Occupational Exposure / / | | 15. Time of Injury (circle one) AM PM | | 16. Shift (circle one) Day Swing Night | |
| 3. Social Security Number | | 4. Home Phone () | | 5. Birthdate / / | | 17. Have you ever been treated for same or similar condition? (circle one) YES NO | | | |
| 6. Home Address | | | | 7. Height (Ft-Inch) | | 18. Is this condition due to a specific incident? (circle one) YES NO | | | |
| City | | State | | ZIP Code | | 19. Tell us what body part was injured and how the injury or exposure occurred. (Include tools, machinery, chemicals or fumes that may have been involved) | | | |
| 9. Mailing Address (if different from home address) | | | | 10. Marital Status (circle one) Married Widowed Separated Single Divorced | | 20. Were you doing YES your regular job? NO | | 21. Where did the injury or exposure occur? (circle one) Employer Premises Jobsite Other: | |
| City | | State | | ZIP Code | | 22. Address where injury or exposure occurred? (Business Name if at Business Location) | | | |
| You may be required to show proof of marital or dependent eligibility | | | | 11. Dependent Children Include unborn, estimate birthdate. Benefits will be based in part on number of legally dependent children. If you don't have custody, complete item 13. | | 12. Spouse's Name | | | |
| Name | | Relationship | Legal Custody (circle one) Y N | Birthdate / / | | Address | | County | |
| | | | Y N | / / | | City | | State ZIP Code | |
| | | | Y N | / / | | 23. Was this incident caused by failure of a machine or product OR someone who is not a co-worker? (circle one) YES NO POSSIBLY | | | |
| | | | Y N | / / | | 24. List any Witnesses | | 25. When will you return to work? / / | |
| | | | Y N | / / | | | | 26. When did you last work? / / | |
| | | | Y N | / / | | 27. Did you report the incident to your employer? Name/Title of Person Reported To | | 28. Date you reported it / / | |
| 13. Name & Address of Children's Legal Guardian | | | | YES NO | | | | | |
| | | | | 29. Was you employer contributing to your and/or family's medical, dental and/or vision insurance on the day you were injured? (circle one) YES NO | | | | | |
| 30. Business Name of Employer | | | | 31. Type of Business | | 32. How long have you worked there? ____ Years ____ Months ____ Weeks ____ Days | | 33. Employer's Phone # () | |
| 34. Employer Address | | | | 35. Your Job Title & Duties | | | | | |
| City | | State | | ZIP Code | | 36. Rate of Pay at this Job (write amount, circle one) \$ Hour Day Week Month | | 37. Hours Per Day | |
| | | | | | | | | 38. Day Per Week | |
| | | | | | | | | 39. Additional earning (circle all that apply) (daily average) Piecework Tips Commission Bonuses | |
| 40. How may paying jobs do you have? | | 41. Are you? <input type="checkbox"/> Owner <input type="checkbox"/> Partner <input type="checkbox"/> Corp. Officer | | <input type="checkbox"/> Does not apply <input type="checkbox"/> Corp. Shareholder <input type="checkbox"/> Corp. Director <input type="checkbox"/> Optional Coverage | | 42. Signature I declare that these statements are true to the best of my knowledge and belief. In signing this form, I permit health care provider, hospitals, or clinics to release medical reports generated by themselves & others to the Dept. of Labor and Industries. X | | Note: READ LEGAL NOTICES ON LAST PAGE Today's Date / / | |

WORKERS INFORMATION

Keep your claim moving smoothly:

- Help us accurately calculate time-loss benefits for which you may be eligible: Report your marital status and dependents. Be prepared to show documents to verify your information.
- Let us know if you had more than one paying job at the time of the injury. Select a health care provider. You have the right to choose any health care provider who is qualified to treat your condition and is reasonably convenient for you to visit. Qualified health care providers include medical, osteopathic, chiropractic, naturopathic, and podiatric physicians, dentists, optometrists and ophthalmologists. Advanced registered nurse practitioners and physician assistants also may provide treatment.
- It is best to stay in touch with your employer and health care provider. If your health care provider says you cannot work, let your employer know. He/she may be able to find work you can do safely while you recover.
- Tell us if you move or change health care providers.
- Do not pay related medical bills unless we inform you your claim was denied. If a pharmacy requires you to pay, keep the receipt so we can reimburse you if the claim is allowed.
- Keep your claim number handy. It is printed on all correspondence we send you.

Legal Notices:

- False information: RCW 51.48.020 sub section (2) provides: Any person claiming benefits under this title, who knowingly gives false information required in any claim or application under this title shall be guilty of a Class C felony when such claim or application involves an amount of five hundred dollars (\$500) or more. When such claim or application involves an amount less than \$500, the person giving such information shall be guilty of a gross misdemeanor.
- Medical Release: RCW 51.36.060 provides: All medical information in the possession or control of any person and relevant to the particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative and the department upon request, and no person shall incur any legal liability by reason of releasing such information.
- Social Security Number Disclosure: Disclosure of your social security number is not mandatory, it is requested as part of your application for compensation under Chapter 51.28 RCW and will be used to facilitate the handling of your claim under Title 51 RCW.

This is your claim number: **AG 38845**

Keep this card handy when contacting us about your claim or to check if L&I has received your claim.

Name **SAMPLE** Date of injury

Use this card to get medical services for the treatment of your work-related injury or occupational disease.

This card does not mean your claim has been allowed.

✂ Cut this card out. Keep it with you. ✂