



CLAIM SUPPRESSION COMPLAINT

Case No. Dept use only

Worker Information

Any party may assist the worker in completing this form and in filing a complaint.

Worker's full name			Date
Present address			
City		State	ZIP
Worker's phone no.			
Were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury claim no. (if applicable)	Date of injury (if applicable)	Did you miss work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Still off work
Has employment been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date alleged act of claim suppression occurred		
Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full duty <input type="checkbox"/> Light duty		Still under medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of medical provider

Attorney Information

If you have an attorney or if you are an attorney filing this complaint, please complete this section.

Do you have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of attorney	Phone Number of attorney
Address of attorney		

Employer Information

Employer	Supervisor's name		
Date Hired	Type of business	Department worked	
Business name (if different)	Phone no.	Job title	
Address	City	State	ZIP

What did your employer say or do to keep you from filing a worker's compensation claim?

What did your employer say or do to keep you from filing a worker's compensation claim? (Continued)

Were there any witnesses to the employer's action? If so, please provide their names and how they may be contacted.

Have you filed your complaint with another agency?

Yes No

If so, which agency have you contacted?

I certify that the information I provided on this form is true to the best of my knowledge.

Print name of person completing this form	Date	Signature of person completing this form
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Mail completed form to: Department of Labor and Industries
Investigations Program
PO Box 44277
Olympia WA 98504-4277

Your rights are:

RCW 51.28.010 Suppression of workers' compensation claims

No employer shall engage in claim suppression by inducing employees to fail to report injuries; inducing employees to treat injuries in the course of employment as off-the-job injuries; or acting otherwise to suppress legitimate industrial insurance claims.

Claim suppression does not include bona fide workplace safety and accident prevention programs or an employer's provision at the worksite of first aid as defined by the Department of Labor & Industries.

If the director determines that an employer has engaged in claim suppression and, as a result, the worker has not filed a claim for industrial insurance benefits as prescribed by law, then the director in his or her sole discretion may waive the time limits for filing a claim provided in RCW 51.28.050, if the complaint or allegation of claim suppression is received within two years of the worker's accident or exposure. For the director to exercise this discretion, the claim must be filed with the department within ninety days of the date the determination of claim suppression is issued.

RCW 51.28.050: No application shall be valid or claim thereunder enforceable unless filed within one year after the day upon which the injury occurred or the rights of dependents or beneficiaries accrued, except as provided in RCW 51.28.055 and 51.28.025(5).