Employer Contact Resource for AP's Office

May scan this form into file or EHR - This is ***not*** an LNI documentation requirement

Patient Name:_____ Date: ___/___/____Staff Initial:_____

Staff to Injured Worker → Staff to Employer → Staff to Insurer → Attending Provider

Box A	Box B	Box C	Box D	Box E	Box F Next Page
"Where at work did the injury occur?	"Who is your employer?"	"Is employer self-insured or covered by L&I state fund?" ***Determine which Report Of Accident to give to the worker to complete.***	"Who is the Best person to contact about return-to-work issues?"	***If Self-Insured*:** "Where do we send medical information and bills?"	***If considering time loss:*** Ask employer about availability of light duty and job modification

Staff completes this section

A

Where injured:

☐ Worksite *Location:* _____

☐ Traveling for work Time:_____ am/pm

☐ In parking lot before shift began, during a break, or after shift ended

☐ Other:

B

Employer: _____ Phone:_____

Address_____ Supervisor's Name:_____

C

☐ State Fund (L&I)

☐ Self-Insured's name: _____

Phone Number: ( )_____ (If known)

Other type of Insurer? ☐ Retrospective Rating (L&I)

☐ Employer Self-Administered

☐ Third Party Administered

D

☐ Owner/Employer

☐ Human Resource (HR)

☐ Corporate HR

☐ Third Party Administrator

☐ Retro Group Representative

☐ Supervisor

☐ Safety Officer

☐ Human Resources staff

☐ Other:

Best person to talk to about return to work issues:

Name:_____

Position title: _____

Phone #: _____

Job description/analysis available: ☐ No ☐ Yes, ☐ Fax to us?

Where to send reports and bills

E

☐ *FOR:*

L&I State Fund	**Medical**	**Billing**
PO Box:	44299	44269
Olympia, WA 98504:	-4299	-4269

☐ **Self-Insured**:_____

Address_____

_____

Phone #:( )_____

FAX #: ( )_____

Online link:_____

Self-Insured Billing:

☐ Same as medical Information

Address:_____

_____

Phone Number: ( )_____

e-mail address: ( )_____

Online link:_____

Provider completes this section

If considering certifying time loss

F

☐ **Time Loss is anticipated:**

Estimate # days off:_____ Dates: from _____/_____ to: _____/_____

DOCTOR TO EMPLOYER

☐ **WORK MODIFICATION NEEDS:**

- ☐ Scheduled Hours
- ☐ Work Task Modification
- ☐ Assisted Work
- ☐ Light Duty (Different Work)
- ☐ Other _____

EMPLOYER'S ABILITY TO ACCOMMODATE: (request a job description if available)

Hours:_____

Task:_____

Assist:_____

Light Duty:_____

Other:_____

Complete the APF *Include the following*

Name of employer contact: _____

Date/Time of contact:_____

Be sure to include

--Which accommodation options were agree to:

- ☐ Light duty
- ☐ Graduated return to work
- ☐ Administrative modification (reduced hours, assisted tasks)
- ☐ Workstation modification
- ☐ Stay at Work Program
- ☐ Job Modification
- ☐ Other: _____
- ☐ None available