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 Number	
Date Requested	
Date of Injury	

How to apply: 1) Complete and sign this section of this form. 2) Take form to your employer and vocational counselor to complete. 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

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 _____

Vocational Counselor's Section

NOTE: This information can be given verbally as long as the written documentation is submitted to the department.

Which of the following applies to this worker? ❒ Retraining Plan ❒ Modified/Lighter Duty ❒ Reduced hours
❒ Reduced wages What is the anticipated end date? _____
Is the worker fulfilling all responsibilities to aid in his/her return to work? ❒ Yes ❒ No If no, why not?

Comments:

Phone #	Date	Counselor's signature

RESET