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	r
					Date Requeste	d
					Date of Injury	
				section employ 3) Mail	er and vocationa	Take form to your l counselor to complete. to the above address.
Worker's Sectio	n					
At the time of injur	y, I was working:	hours per day	days per w	eek.		<u></u>
I am currently world		hours per day	days per w	eek.		
My gross earnings	, before deduction	ns, for the work period:	to _		were \$_	
insurance benefits,	or providing hous	employer paying any part of ing, board and/or fuel (utilities)	es)?	☐ No		
Are you still receiv	•				_	e ended
		employer is/was paying for n				
will be required to re	fund my benefits ar	owing: I understand that if I nnd I may face civil or criminal rreleases me for full duty, if I	penalties. I unde	rstand I	must report on the	his form any work
Date	Work	er's signature				
		er's signature  completed by employer or a c				
Date  Employer's S  Wages were paid for	ection To be or the period	completed by employer or a c	Gross		d for the above poaid \$	
Date  Employer's S  Wages were paid for During this period:	ection To be or the period # work hours av	completed by employer or a control to to #	Gross	Wage p	oaid \$	
Date  Employer's S  Wages were paid for During this period: Were vacation wage	ection To be or the period# work hours aves paid during this	completed by employer or a completed by employer or a completed by employer or a complete by emp	Gross hours worked No	Wage p	paid \$Amount paid \$_	
Employer's S Wages were paid for During this period: Were vacation wag Were sick leave was	ection To be or the period # work hours av ges paid during this ages paid during th	completed by employer or a completed by employer or a comparison of the complete com	Gross hours worked _ No   No	Yes A	Amount paid \$_ Amount paid \$_	
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