Washington State Department of Labor & Industries

Wage Loss Notification

Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520
Phone 800-762-3716 Fax 360-902-5333

Today's Date:	Date of Injury:	Claim Number	Name

To determine eligibility for wage loss compensation, both Claimant and Provider sections need to be completed and return to L&I.

Persons making false statements to obtain Crime Victims Compensation benefits are subject to civil and/or criminal penalties under law.

Claimant's Statement

Due to my crime related injury/illness, I have not, nor was I able to work from :

_____ to _____
Start Date End Date

I have applied for the following benefits:

	Date of application		Date of application
☐ None		☐ Other public assistance	
☐ Unemployment		☐ Social Security	
☐ Paid Family Leave		☐ Retirement	

I returned to work on: _____ (any type of work, including self-employment)

☐ Full time, no restrictions ☐ Part time - _____ hours per day ☐ Modified duties

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and further that: 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 immediately notify my claim manager if I perform any work (paid or unpaid), if my doctor releases me for work, if I am incarcerated and under sentence, or if the custody of my children changes.

Date	Place	Signature

Doctor's Statement

Diagnosis due to injury:	
Date of last treatment	Date of next scheduled appointment

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I certify this Patient is unable to return to any type of work: From (start date) To (end date)	
Patient is released for work on:	I expect to release patient to return to work on:
Please list any restrictions, indicate if they are temporary or permanent. Include any Objective Medial Findings (OMF) to support these restrictions. **Time Loss cannot be paid without OMF to support inability to work due to crime injury.**	
Has the patient's condition(s) resulting from the crime injury reached maximum medical improvement? ☐ Yes ☐ No	
Remarks	

Physician's name (print or type – must be legible)		Provider Account number
Address	City	State Zip Code
Phone Number	Email Address	

Date Place Signature

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