

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: _____



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: <input type="checkbox"/> Worksite Location: _____ <input type="checkbox"/> Traveling for work Time: _____ am/pm	<input type="checkbox"/> In parking lot before shift began, during a break, or after shift ended <input type="checkbox"/> Other: _____
B	Employer: _____ Address: _____	Phone: _____ Supervisor's Name: _____
C	<input type="checkbox"/> State Fund (L&I) <input type="checkbox"/> Self-Insured's name: _____ Phone Number: () _____ (If known)	Other type of Insurer? <input type="checkbox"/> Retrospective Rating (L&I) <input type="checkbox"/> Employer Self-Administered <input type="checkbox"/> Third Party Administered
D	<input type="checkbox"/> Owner/Employer <input type="checkbox"/> Human Resource (HR) <input type="checkbox"/> Corporate HR <input type="checkbox"/> Third Party Administrator <input type="checkbox"/> Retro Group Representative	<input type="checkbox"/> Supervisor <input type="checkbox"/> Safety Officer <input type="checkbox"/> Human Resources staff <input type="checkbox"/> Other: _____

Best person to talk to about return to work issues:

Name: _____

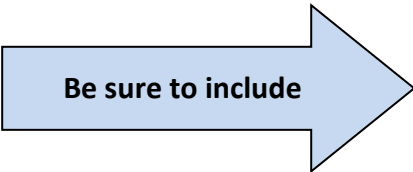
Position title: _____

Phone #: _____

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

Where to send reports and bills					
E	<input type="checkbox"/>	FOR:		<input type="checkbox"/> Self-Insured: _____	Self-Insured Billing:
	L&I State Fund	Medical	Billing	Address _____	<input type="checkbox"/> Same as medical Information
	PO Box:	44299	44269	_____	Address: _____
	Olympia, WA			_____	_____
	98504:	-4299	-4269	Phone #:() _____	Phone Number: () _____
				FAX #: () _____	e-mail address: () _____
				Online link: _____	Online link: _____

Provider completes this section

If considering certifying time loss	
F	<input type="checkbox"/> Time Loss is anticipated: Estimate # days off: _____ Dates: from ____/____/____ to: ____/____/____
DOCTOR TO EMPLOYER	<input type="checkbox"/> WORK MODIFICATION NEEDS: <input type="checkbox"/> Scheduled Hours <input type="checkbox"/> Work Task Modification <input type="checkbox"/> Assisted Work <input type="checkbox"/> Light Duty (Different Work) <input type="checkbox"/> Other _____
	EMPLOYER'S ABILITY TO ACCOMMODATE: (request a job description if available) Hours: _____ Task: _____ Assist: _____ Light Duty: _____ Other: _____
	Complete the APF <i>Include the following</i> Name of employer contact: _____ Date/Time of contact: _____ <div style="text-align: center; margin-top: 20px;">  </div>
	--Which accommodation options were agree to: <input type="checkbox"/> Light duty <input type="checkbox"/> Graduated return to work <input type="checkbox"/> Administrative modification (reduced hours, assisted tasks) <input type="checkbox"/> Workstation modification <input type="checkbox"/> Stay at Work Program <input type="checkbox"/> Job Modification <input type="checkbox"/> Other: _____ <input type="checkbox"/> None available

