

Department of Labor and Industries  
 Claims Section  
 PO Box 44291  
 Olympia WA 98504-4291



**APPLICATION FOR  
 L.E.P. COMPENSATION  
 MED**

Unit	Work Position
Claim Number	
Date Requested	
Date of Injury	

*c/o* PALACE LAW OFFICES  
 PO Box 1193  
 Tacoma, WA 98401-1193  
 (253) 627-3883

How to apply: 1) Complete and sign the worker section of this form 2) Have your employer and attending physician complete their sections. 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
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**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
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Date	I certify that the earnings shown above are correct, according to our records.	
	Employer's signature	Title

**Physician's Section**

Diagnosis due to workplace injury or illness: \_\_\_\_\_  
 The present disability allows the worker to perform only  Modified/lighter duty  
 Reduced hours # hours per day \_\_\_\_\_ # days per week \_\_\_\_\_  
 List and explain physical restrictions: \_\_\_\_\_

Have you advised the worker to return to pre-injury work schedule or pre-injury duties?  No  Yes, on \_\_\_\_\_  
 If No, when do you anticipate the worker will be able to return to pre-injury work schedule or pre-injury duties? \_\_\_\_\_

Are there factors impeding recovery, such as unrelated medical conditions, socio-economic or chemical dependency?  Yes  No  
 If yes, explain and use additional sheets if needed.

Has the worker's condition, due to this injury, reached maximum medical improvement?  Yes  No

Will permanent impairment result from this injury?  Yes  No  Undetermined

Comments: \_\_\_\_\_

Phone #	Date	Physician's signature
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