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

APPLICATION FOR L.E.P. COMPENSATION MED

Complete form in FULL for prompt action

Name (first, middle, last), address, city, state and ZIP

Unit Work Position
Claim No.
Date Requested
DOI

WORKER'S SECTION

IMPORTANT: The department has been informed that you have returned to work part-time, or are working at a lighter duty job than performed at the time of injury. Take this form to your employer and attending physician for completion. This form must be completed and returned to the Department of Labor & Industries, so Loss of Earning Power eligibility can be reviewed.

Are you presently working full time? ☐ Yes ☐ No
If no, how many hours per day and days per week do you work?

What were your total gross earnings, including your employer's contribution to your and/or your family's medical, dental and/or vision insurance?
___/___/___ to ___/___/___

$ ____________

NOTE: Persons making false statements in obtaining industrial insurance benefits are subject to civil and criminal penalties.
I declare that these statements are true to the best of my knowledge and belief.

Date	Worker's signature **X**

EMPLOYER'S SECTION

Wages were paid for the above period in the amount of $__________.___.

If you are contributing to the worker and/or the worker's family medical, dental and/or vision insurance, what was your daily contribution for this period? $__________.

Were ☐ Vacation or ☐ Sick leave wages paid during the period? ☐ Yes ☐ No If so, how much? $__________

You may attach payroll slips for this period.

Date	I certify that the earnings shown by the worker are correct according to our records. Employer's signature **X**

PHYSICIAN'S SECTION

The present disability allows the worker to perform only ☐ modified/lighter duty. ☐ part-time work.

Explain and list physical limitations:

Is the worker's inability to return to full time employment due to industrial injury? ☐ Yes ☐ No

Has the worker's condition reached maximum medical improvement? ☐ Yes ☐ No

Are there factors that are impeding recovery (e.g., unrelated conditions, socioeconomic, chemical dependency)?
☐ Yes ☐ No

If yes, explain below and use additional sheets if needed.

If no, when do you anticipate maximum medical improvement?
___/___/___

If yes, date of maximum medical improvement.
___/___/___

Please complete the following, use additional sheets if needed.

☐ No permanent impairment
☐ Impairment undetermined (explain)
☐ Permanent impairment (explain)

When did you last treat the worker? ___/___/___
Have you advised the worker to return to full time work?
☐ Yes ☐ No If yes, on what date? ___/___/___

If no, when do you anticipate the worker will be able to return to full time work? ___/___/___

Comments:

Phone # ( )	Date	Physician's signature **X**