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



## **WORKER VERIFICATION FORM**

Work Position

Unit

Claim number

			Date of request
			Date of injury
Instructions to worker	: This is your request for tim	ne-loss compensation.	This must be completed before we can
consider you for benefit	s. If you are unable to work	due to your workplace	injury AND your employer is not paying
	omplete this form 2) Sign a		
3) Mail it to the address	above within 14 days of the	date you received this:	mailing.
ame Phone number		ıber	
Address PUTNAM & LIEB			Fill in ONLY if you have a new address
OLYMPIA, WA 98507-033		17	and/or phone number.
City	State	ZIP	<del></del>
,			
Worker's Stateme	nt	•	
This includes, but is no		it, COPES or CHORE	lness from to Services. Did you engage in other work type cribe:
T *11/1*1	1 T 1 T	T	
I will/did return to work on	I am now working Hours/Day	I am now working Days/Week	My current wage is: \$ per ☐ Hour ☐ Day ☐ Week ☐ Month
WORK OIL	Trours/Day	_ Days/ WCCK	Hour Li Day Li Week Lindonth
I have applied for the fol	lowing  None	☐ Food stamps only	☐ Social Security benefits
benefits:	Unemployment	Other public assist	•
On the date of your inj	ury, was your employer payi	ng any part of your and	d/or your family's medical, dental and/or vision
insurance benefits, or p	providing housing, board and	/or fuel (utilities)?	Yes 🗖 No
Ara vou ctill ragaiving	these benefits?	Na data aayawaaa anda	.J
Are you sim receiving	these belieflis?	No, date coverage ende	:u
			nake a false statement about my activities or
			face civil or criminal penalties. I understand
	othy my claim manager it i rated and under sentence, o		paid or unpaid), if my doctor releases me for y children changes.
Phone # Da		•	, variatell ellerigesi
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