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

WORKER VERIFICATION FORM

Unit	Work Position
Claim number	
Date of request	
Date of injury	

Instructions to worker: This is your request for time-loss compensation. This must be completed before we can consider you for benefits. If you are unable to work due to your workplace injury AND your employer is not paying your full wages: 1) Complete this form 2) Sign and date
3) Mail it to the address above within 14 days of the date you received this mailing.

Name	Phone number	
Address C/O PUTNAM & LIEB ~~P.O. BOX 337~~ OLYMPIA, WA 98507-0337		
City	State	ZIP

Fill in ONLY if you have a new address and/or phone number.

Worker's Statement

I did not perform any work, paid or unpaid, due to a work-related injury/illness from __________ to ____________.
This includes, but is not limited to, self-employment, COPES or CHORE Services. Did you engage in other work type activities such as volunteer work? ☐ Yes ☐ No If so, please describe: ______________________________

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

I have applied for the following benefits: ☐ None ☐ Unemployment ☐ Food stamps only ☐ Other public assistance programs ☐ Social Security benefits

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 _______________

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 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.**

Phone #	Date	Worker's signature