Department of Labor & Industries
Self Insurance Section
PO Box 44892
Olympia WA 98504-4892

SIF-5 SI REPORT ON OCCUPATIONAL INJURY OR DISEASE

(ALL INFORMATION MUST BE COMPLETED)

Employer	UBI	Account ID	Claim No.

Service Co.

- ☐ INITIAL: On the date first time loss is paid
- ☐ INTERLOCUTORY ORDER REQUEST
- ☐ FINAL: On the date claim is closed by employer
- ☐ FINAL: On the date final determination is requested
- ☐ SUPPLEMENTAL: Upon Department Request
- ☐ SUPPLEMENTAL: Correction of Previous SIF 5
- ☐ WAGE ORDER requested (SIF-5A and appropriate documentation attached)
- ☐ OVERPAYMENT ORDER REQ. (SIF-5A and appropriate documentation attached)

FOR FINAL SIF-5: If the employer stopped contributing to health care benefits, list the date the employer's payment ended for each type.

Medical: _____

Dental: _____

Vision: _____

Claimant			Address
Date of injury	Last day worked	Date of lst payment	
Claim arrival date	Date returned to work	Date released for work	
Date first treated			

COMPENSATION PAID

From	through	@ $	per	days totaling
From	through	@ $	per	days totaling
From	through	@ $	per	days totaling
From	through	@ $	per	days totaling

☐ Time Loss Compensation	Total number of time loss days paid	Total time loss amount paid $
☐ Loss of Earning Power (see attachment for documentation)	Total number of LEP days paid	Total LEP amount paid $

Is condition medically fixed?	Is there a permanent impairment?	Attending physician
Has claimant returned to same employer?	Has time loss exceeded 90 days?	Address
E.A.R. approval date	Return to work priority (A-I)	City State ZIP

Rehab Outcome Report			Remarks
Code #	Type	Cost	

Complete for Claim Closure only

- ☐ **Time loss** ☐ **Treatment only**
- ☐ **All requirements for closure of this claim by the self-insured employer have been met and are documented in our file.**
- ☐ **Final determination request of the Department of Labor and Industries. Copies of medical report and pertinent information attached.**

Notice: At time of final determination, no further medical services are authorized subsequent to the date of this report.

L&I use only

I hereby certify that I have addressed the value of the employer's contribution to any health insurance benefits and included it in the time loss rate if appropriate.

Date	Authorized Representative

RESET

NOTE: SUBMIT 1 COPY OF THIS FORM TO THE CLAIMANT AND 1 COPY TO LABOR & INDUSTRIES