Washington State Department of Labor & Industries

Suspension Request Coversheet

Claim Number: _____ Worker's Name: _____
Request submitted by:_____ Phone Number: _____

Type of Non-Cooperation:

- ☐ Not attending or cooperating with medical examinations or vocational evaluations requested by the department or self-insurer.
- ☐ Failure to keep scheduled appointments or evaluations with attending physician or vocational counselor.
- ☐ Engaging in unsanitary or harmful actions that jeopardize or slow recovery.
- ☐ Not accepting medical and/or surgical treatment that is considered reasonably essential for recovery from the industrial injury or occupational disease.
- ☐ Refusal of the worker to transfer care to a provider in the Medical Provider Network (MPN).
- ☐ Failure to follow retraining plan Accountability Agreement/jeopardizing plan completion.

Attempts to Avoid Non-Cooperation:

- ☐ Phone call made to worker/attorney discussing non-cooperative behavior and explaining consequences. **Attach Copy** of all logged phone calls.
- ☐ Informal letter sent recapping conversation or giving additional information. **Attach Copy.**

Requirements:

- ☐ Formal non-cooperation letter sent to the worker that includes all of the following (**Attach Copy):**
  - ☐ An explanation of the problem, including specific actions expected of the worker.
  - ☐ Reference RCW 51.32.110, and include the specific language related to the worker non-cooperation issue.
  - ☐ Request that the worker provide the reasons for the non-cooperation.
  - ☐ Notice that benefits can be suspended as a result of the non-cooperation.
  - ☐ Inform the worker that per WAC 296-14-410 they have 30 calendar days from the date of the letter to respond in writing to the request for the reasons for the non-cooperation.
- ☐ If the worker is non-cooperative during retraining (see above) provide the department an explanation of how the worker's actions impact(ed) the plan and whether the plan can be salvaged, per RCW 51.32.099 (3)(a) and (5)(a-c).

Worker Response:

- ☐ The worker did not respond to the request for good cause.
- ☐ The worker responded but didn't show good cause. **Attach Copy** of Worker Response.

Request:

- ☐ I request the department issue an order to suspend the following benefits under this claim:
  - ☐ Time-loss/loss of earning power
  - ☐ Medical
  - ☐ Vocational
  - ☐ All benefits

Note: If all required information is not received, the request will be denied.
For more information on claim suspension go to the Miscellaneous Claims Issues section of the Claim Adjudication Guidelines.