

Self-Insurance
PO Box 44892
Olympia WA 98504-4892
Fax: 360-902-6900

Injured Worker Name		Claim Number	
Injured Worker Address			
City		State	Zip Code
Date of Injury or Manifestation		Date Form Completed	
Employer Name		UBI	Account ID
Prepared By		Preparer Phone Number (include extension if needed)	

SIF-2: Please ensure the completed SIF-2 is attached to this form, if not previously submitted to the claim file. This must be date stamped ([RCW 51.32.190](#)).

Allowance Request and Compensation Paid

Type of Claim <input type="checkbox"/> Specific Injury <input type="checkbox"/> Occupational Disease <input type="checkbox"/> Hearing Loss		Date of First Treatment
Has Time-Loss and/or LEP been started on this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> KOS		
Condition(s) at Claim Allowance		

Attending Provider Information or Update

Please provide the current attending provider information.

Attending Provider Name		Attending Provider's Phone Number
Attending Provider's Address		
City		State Zip Code

Translation for Communicating the Decision

It is necessary the Employer and the Department ensure a means of communication to all parties per [WAC 296-15-350](#).

Does the worker have a preferred language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", what is the preferred language?
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