Washington State Department of Labor & Industries

Claim Closure

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)*.

Closure Request or Reporting and Compensation Paid

Has compensation been paid on this claim? ☐ Yes ☐ No	Are you reporting an employer closure (EC)? ☐ Yes ☐ No		Is there PPD on the claim? ☐ Yes ☐ No
Last Day Worked*	Returned to Work*	Released to Work*	Compensation Paid Through Date
Provide PPD description and any prior PPD paid.			

Total TL Amount Paid	Total TL Days Paid	Total LEP Amount Paid	Total LEP Days Paid	RTW with SIE? ☐ Yes ☐ No

Claim closure remarks and description of supporting documentation for closure request (*Please attach the supporting documentation directly behind this form. If compensation benefits were paid, ensure a copy of the SIF-5A and a payment ledger has been included with the complete copy of this claim file.)* **If multiple dates listed, please provide explanation.*

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? ☐ Yes ☐ No	If "Yes", what is the preferred language?

RESET

Index: **CCR**