

Statement of Facts

Questions below are required to evaluat	te your request for reopening. See continuation	on sheets if more space is required.
Worker's Name	Claim Number	
Current Conditions		
List area(s) of pain:		
How did your condition worsen after closure	?	
How is this related to your industrial laive 2		
How is this related to your industrial Injury?		
Why do you want your claim reopened?		
When and with whom did you seek med	lical treatment after your claim closure?	
Provider Name:	Phone number	er
Street Address	City	State Zip
Dates of treatment:		
Provider Name:	Phone numb	er
	0.1	01-1
Street Address	City	State Zip
Dates of treatment:		
use continuation sheet at back for additional provi	ders	
Freatment History		
	below, please include provider information in ne	
Have you had any new injuries since cla Description of Injuries:		any treatment?: Yes No
Date(s) of injuries:		
Are any new injuries the result of a car a		
Do you have claims with any other insur	rance companies 🔲 Yes 🗌 No	
List Claims:		

Name of Company(s) or Insurer(s):

F242-017-000 Statement of Fact 01-2018

Worker's Name	C	Claim Number			
Provider Information					
Provider Name:		Phone r	number		
Street Address		City		State	Zip
Dates of treatment:					
Provider Name:		Phone r	number		
Street Address		City		State	Zip
Dates of treatment:					
Provider Name:		Phone r	number		
Street Address		City		State	Zip
Dates of treatment:					
Employment History					
Name of Employer at time of Injury	Γ	Date of Injury			
List all Employers since your injury					
Current Employer Name:		Phone r	number		
Street Address		City		State	Zip
Job Title:	Job Duties:				
Date of Employment:					
How many hours per day did you perfo	rm the following tasks?				
Pushing/Pulling	Overl	head Work		Keyboard	ding
Lifting	Knee	ling		Gripping	
Prior Employer:		Phone r	number		
Street Address		City		State	Zip
Job Title:	Job Duties:	1		<u> </u>	<u> </u>
Dates of Employment From _	// to	//			
How many hours per day did you perfo	rm the following tasks?		1		
Pushing/Pulling	Overl	head Work		Keyboard	ding
Lifting	Knee	ling		Gripping	

F242-017-000 Statement of Fact 01-2018

Worker's Name Claim Number

Prior Employer:: Phone number Street Address City State Zip Job Title: Job Duties:						
Job Title: Job Duties: Dates of Employment From// to/_/ How many hours per day did you perform the following tasks?	Prior Employer::		Phone n	umber		
Job Title: Job Duties: Dates of Employment From// to/_/ How many hours per day did you perform the following tasks?						
Dates of Employment From// to/_/ How many hours per day did you perform the following tasks? Pushing/Pulling Normanian Lifting Prior Employer: Prior Employer: Prior Employer: Phone number Street Address City Street Address Ob Duties: Dates of Employment From// to/ How many hours per day did you perform the following tasks?	Street Address		City		State	Zip
Dates of Employment From// to/_/ How many hours per day did you perform the following tasks? Pushing/Pulling Normanian Lifting Prior Employer: Prior Employer: Prior Employer: Phone number Street Address City Street Address Ob Duties: Dates of Employment From// to/ How many hours per day did you perform the following tasks?						
How many hours per day did you perform the following tasks? Pushing/Pulling Overhead Work Gripping Lifting Kneeling Gripping Prior Employer: Phone number	Job Title:	Job Duties:	·			
How many hours per day did you perform the following tasks? Pushing/Pulling Overhead Work Gripping Lifting Kneeling Gripping Prior Employer: Phone number						
Pushing/Pulling Overhead Work Keyboarding Lifting Kneeling Gripping Prior Employer: Phone number State Street Address City State Zip Job Title: Job Duties:	Dates of Employment From	/ to	<u> </u>			
Lifting Kneeling Gripping Prior Employer: Phone number Street Address City State Zip Job Title: Job Duties: State Zip Dates of Employment From // to // How many hours per day did you perform the following tasks? Overhead Work Keyboarding Pushing/Pulling Overhead Work Gripping Lifting Kneeling Gripping	How many hours per day did you perf	orm the following tasks?				
Prior Employer: Phone number Street Address City State Zip Job Title: Job Duties:	Pushing/Pulling	Overh	ead Work	ŀ	Keyboard	ling
Prior Employer: Phone number Street Address City State Zip Job Title: Job Duties:	Lifting	Kneel	ing	(Gripping	
Job Title: Job Duties: Dates of Employment From// to// How many hours per day did you perform the following tasks? Pushing/Pulling Overhead Work Keyboarding Lifting Kneeling Gripping Are you retired from the work force? Yes No If yes, date you retired:						
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Dates of Employment From// to// How many hours per day did you perform the following tasks? Pushing/Pulling Overhead Work Keyboarding Lifting Kneeling Gripping Are you retired from the work force? Yes No If yes, date you retired:	Street Address		City		State	Zip
Dates of Employment From// to// How many hours per day did you perform the following tasks? Pushing/Pulling Overhead Work Keyboarding Lifting Kneeling Gripping Are you retired from the work force? Yes No If yes, date you retired:						
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Lifting Kneeling Gripping Are you retired from the work force? Yes No If yes, date you retired:				1		
Are you retired from the work force?	Pushing/Pulling	Overh	ead Work	ł	Keyboard	ling
	Lifting	Kneel	ing	(Gripping	
	Are you retired from the work force?		voc. data vou rati	rod		
			yes, date you reti	ieu		
Are you receiving Social Security Benefits? Yes No If yes, date benefits started:			If yes, date be	enefits started:		
Please list reason for Social Security Benefits:	Please list reason for Social Security	Benefits:				
If not currently working, please explain:	If not currently working, please explain	า:				

Worker Statement: By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. Further I understand a false statement might result in civil or criminal penalties.

Signature:	Date

Worker's Name	Claim Number

Continuation Sheet

Additional Providers

Provider Name:	Phone	e number		
Street Address	City	S	State	Zip
Dates of treatment:				
Provider Name:	Phone	e number		
Street Address	City	S	State	Zip
Dates of treatment:				
Provider Name:	Phone	e number		
Street Address	City	S	State	Zip
Dates of treatment:				

Additional Employers

Prior Employer::		Phone number		
Street Address	City		State	Zip
Job Title:	Job Duties:			l
Dates of Employment From _	// to/	_/		
How many hours per day did you perfo	rm the following tasks?	I		
Pushing/Pulling	Overhead W	ork	Keyboard	ling
Lifting	Kneeling		Gripping	
Prior Employer:		Phone number		
Street Address	City		State	Zip
	Job Duties:		State	Zip
Job Title:			State	Zip
Job Title:	Job Duties:		State	Zip
Job Title: Dates of Employment From _	Job Duties:		State	