Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

Statement of Facts

Questions below are required to evaluate your request for reopening. See continuation 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 Injury?

Why do you want your claim reopened?

When and with whom did you seek medical treatment after your claim closure?

Provider Name: Phone number

Street Address City State Zip

Dates of treatment:

Provider Name: Phone number

Street Address City State Zip

Dates of treatment:

use continuation sheet at back for additional providers

Treatment History

If answering yes to any of the questions below, please include provider information in next section.

Have you had any new injuries since claim closure? ☐ Yes ☐ No Did you seek any treatment?: ☐ Yes ☐ No

Description of Injuries:

Date(s) of injuries:

Are any new injuries the result of a car accident? ☐ Yes ☐ No | Date(s)

Do you have claims with any other insurance companies ☐ Yes ☐ No

List Claims:

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

RESET

Worker's Name	Claim Number

Provider Information

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

Employment History

Name of Employer at time of Injury	Date of Injury

List all Employers since your injury

Current Employer Name:	Phone number		
Street Address	City	State	Zip
Job Title:	Job Duties:		
Date of Employment:			
How many hours per day did you perform the following tasks?			
_____ Pushing/Pulling	_____ Overhead Work	_____ Keyboarding	
_____ Lifting	_____ Kneeling	_____ Gripping	

Prior Employer:	Phone number		
Street Address	City	State	Zip
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	

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Worker's Name	Claim Number

Prior Employer::			Phone number	
Street Address		City	State	Zip
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		

Prior Employer:			Phone number	
Street Address		City	State	Zip
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: _____
Please list reason for retirement:	
Are you receiving Social Security Benefits? ☐ Yes ☐ No	If yes, date benefits started: _____
Please list reason for Social Security Benefits:	
If not currently working, please explain:	

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

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Worker's Name	Claim Number

Continuation Sheet

Additional Providers

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

Additional Employers

Prior Employer::		Phone number	
Street Address	City	State	Zip
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	
Prior Employer:		Phone number	
Street Address	City	State	Zip
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	

RESET