Request for Claim Information

For the worker or worker's representative
OR
The employer or employer's representative

For State Fund Claims Mail To:
Department of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

For Self-Insured Claims Mail To:
Self-Insurance
PO Box 44892
Olympia WA 98504-4892

This form must be completed in full. Copies of documents are a chargeable item.

Claim Number
Worker's Name

Name of Person Making Request		I am ☐ Worker ☐ Other
Address		
City	State	Zip Code

☐ I am requesting my claim file.

☐ I am requesting the following information from my claim file (*for example: "The panel exam of February 2, 2013" etc.):*

☐ I am the worker's authorized representative requesting the claim file for the worker named above. I understand that the file contains confidential information and by accepting the file, I accept full responsibility for any use made of this information. My authorization is:

☐ On File ☐ Attached

☐ I am the employer or employer's representative requesting the claim file for the worker named above. I understand that the file contains confidential information and by accepting the file, I accept full responsibility for any use made of this information.

Signature ______________________ Date ______________

For Department Use Only

Action taken on request:		
Name of Person Taking Action:	Date Action Taken:	Section/Office: