Washington State Department of Labor & Industries

Claim Allowance Request

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 ☐ Specific Injury ☐ Occupational Disease ☐ Hearing Loss	Date of First Treatment
Has Time-Loss and/or LEP been started on this claim? ☐ Yes ☐ No ☐ 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? ☐ Yes ☐ No	If "Yes", what is the preferred language?