L&I WORK HARDENING DATA FORM

- Complete this form for every State Fund WH client
- Send to L&I WITHIN ONE WEEK of WH DISCHARGE: **FAX: 360-902-5035**
- Or Mail to: WH REVIEWER, L&I, PO BOX 44324, OLYMPIA, WA 98504-4324

WH FACILITY NAME	CLAIM NUMBER
PROVIDER GROUP NUMBER	WORKER NAME
If applicable, ASSIGNED VOCATIONAL PROVIDER COMMUNICATION WITH VOC? ☐ Prior to start ☐ During ☐ At discharge	ATTENDING PROVIDER PRIMARY CONDITION (check ONE only) ☐ Back ☐ Neck ☐ UE ☐ LE ☐ Other
JOB OF INJURY (JOI) TITLE	INITIAL RTW GOAL JOB TITLE if different than JOI
WH EVALUATION DATE _____ LAST WH VISIT DATE _____ TOTAL # OF WH TX DAYS _____ 30 Max	JOB ANALYSIS (JA) PROVIDED ☐ YES ☐ NO JA PROVIDED AT START OF PGM ☐ YES ☐ NO
JOB SITE VISIT? ☐ YES ☐ NO ☐ N/A	DID WORKER RETURN TO WORK? ☐ YES Date: _____ ☐ Unknown
DID WORKER MEET THE RTW JOB GOAL? ☐ YES ☐ YES WITH MODIFICATION ☐ NO IF NO, DID WORKER MEET BACK UP GOAL? ☐ YES ☐ YES WITH MODIFICATION ☐ NO JOB TITLE:	AVG HRS/DAY IN PROGRAM DURING FINAL WEEK _____HRS IF < 6, INDICATE WHY:

DID WORKER COMPLETE WH PROGRAM PER ORIGINAL PLAN OF CARE? ☐ YES ☐ NO

IF NO, INDICATE REASON(S):

☐ SCREENED OUT (at initial eval)	☐ MET GOAL EARLY	☐ JOB GOAL CHANGED
☐ PROGRAM EXTENDED past 4 weeks.	☐ PROGRAM INTERRUPTED ☐ By worker ☐ By AP ☐ By L&I	☐ ATTENDING DOCTOR RELEASED TO WORK
☐ D/C – LACK OF PROGRESS	☐ OTHER:	

FORM COMPLETED BY: NAME: DATE:

Version: May 2016