### Staff to Injured Worker

**Box A:** “Where at work did the injury occur?”

**Box B:** “Who is your employer?”

**Box C:** “Is employer self-insured or covered by L&I state fund?”

**Box D:** “Who is the Best person to contact about return-to-work issues?”

**Box E:** If Self-Insured: “Where do we send medical information and bills?”

**Box F:** Next Page

### Staff completes this section

#### A Where injured:
- [ ] Worksite  **Location:** ________________________________
- [ ] Traveling for work  **Time:** ________ am/pm
- [ ] In parking lot before shift began, during a break, or after shift ended
- [ ] Other:

#### B Employer:
- **Name:** ___________________________________________
- **Address:** ___________________________________________
- **Phone:** _____________________________
- **Supervisor’s Name:** ___________________________

#### C
- [ ] State Fund (L&I)
- [ ] Self-Insured’s name: ________________________________
  **Phone Number:** (   )_______________________ (If known)
- Other type of Insurer?
  - [ ] Retrospective Rating (L&I)
  - [ ] Employer Self-Administered
  - [ ] Third Party Administered

#### D
- [ ] Owner/Employer
- [ ] Human Resource (HR)
- [ ] Corporate HR
- [ ] Third Party Administrator
- [ ] Retro Group Representative
- [ ] Supervisor
- [ ] Safety Officer
- [ ] Human Resources staff
- [ ] Other:

### Best person to talk to about return to work issues:

- **Name:** ________________________________
- **Position title:** ________________________________
- **Phone #:** ________________________________
- Job description/analysis available: [ ] No  [ ] Yes, [ ] Fax to us?
Where to send reports and bills

<table>
<thead>
<tr>
<th>FOR:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>L&amp;I State Fund</td>
<td>Medical</td>
<td>Billing</td>
</tr>
<tr>
<td>PO Box: 44299</td>
<td>44269</td>
<td></td>
</tr>
<tr>
<td>Olympia, WA 98504: -4299</td>
<td>-4269</td>
<td></td>
</tr>
</tbody>
</table>

Self-Insured Billing:
- Same as medical Information

<table>
<thead>
<tr>
<th>Self-Insured:</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #: ( )</td>
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<tr>
<td>FAX #: ( )</td>
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<tr>
<td>Online link:</td>
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</tbody>
</table>

Provider completes this section

If considering certifying time loss

<table>
<thead>
<tr>
<th>□</th>
<th>Time Loss is anticipated:</th>
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</table>
| Estimate # days off: | Dates: from _____/____ to: _____/_____

□ WORK MODIFICATION NEEDS:
- Scheduled Hours
- Work Task Modification
- Assisted Work
- Light Duty (Different Work)
- Other _______________________

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- Work Task Modification
- Assisted Work
- Light Duty (Different Work)
- Other _______________________

EMPLOYER’S ABILITY TO ACCOMODATE: (request a job description if available)

Hours:__________________________________________________
Task:_________________________________
Assist:__________________________________________________
Light Duty:______________________________________________
Other:__________________________________________________

Complete the APF Include the following

Name of employer contact: _________________________________
Date/Time of contact: _________________________________

--Which accommodation options were agreed to:
- Light duty
- Graduated return to work
- Administrative modification (reduced hours, assisted tasks)
- Workstation modification
- Stay at Work Program
- Job Modification
- Other: _______________________
- None available