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

☐ Department of Labor & Industries
Self-Insurance
PO Box 44892
Olympia WA 98504-4892

# REQUEST FOR CLAIM INFORMATION

(To be completed by worker, worker's representative employer, or employer's representative)

*This form must be completed in full*

Claim No.

Worker's name

Name of person making request ☐ Worker ☐ Other Date Phone

Address

City State ZIP

**Copies of documents are a chargeable item**

*Please check the proper box(s).*

☐ I am requesting my claim file.

☐ I am requesting the following information from my claim file:
*(for example, "the panel exam of Feb 4, 1977," etc.) Please list below.*

☐ 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. 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

For Department use only:

Action taken on request

| Date action taken | Name of person taking the action | Section/office |
|---|---|---|
| | | |