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

EMPLOYABILITY ASSESSMENT REPORT (EAR)

Claim Number:

Employer | Account ID | Injured Worker's Name:

Vocational Referral: ☐ Vocational Assessment ☐ Medical Instability

Explanation: _____

☐ Anticipated Date for the Employability Decision

Self-Insurer's Notification:

Check only one eligibility status and the single best reason for your conclusion based upon the availability of objective information.

A. ☐ Eligible for vocational services.

B. ☐ Able to work.

1. ☐ Worker returned to work on ____/____/____ in a permanent job and condition is stable.

   Priority # _____

2. ☐ Worker can work based on transferable skills.

C. ☐ Not eligible for vocational services due to one of the following:

1 ☐ Pre-existing and progressive condition(s)/unrelated to this claim.

2 ☐ Post conditions/unrelated to this claim.

3 ☐ Direct effects of the industrial injury.

4 ☐ Combined effects (second injury)

5 ☐ Worker's actions.

VR Provider ID:	Branch Number:	VR Provider Name:		
VRC Name:		VRC ID:	VRC Phone Number: ( )	
VRC Address:		City:	State: ZIP+4	
Injured Worker's Name:	Injured Worker's Phone #: ( )	Date of Injury:	Date of Birth:	Age:
Injured Worker's Address:		City:	State: ZIP	
Legal Representative's Name:			Legal Rep's Phone Number: ( )	
Legal Representative's Address:		City:	State: ZIP	
Attending Physician's Name:	Attending Physician's Phone Number: ( )	VR Referral Date:	Days of Cont. TL Paid to Date:	
Attending Physician's Address:		City:	State: ZIP	
Employer or Service Representative's Signature:		Phone No.	Date:	

NOTE: ☐ **File Attached** ☐ **File Previously Sent**

All medical reports and other pertinent information in the Self-Insurer's possession not previously forwarded to the Department must be submitted with this request (WAC 296-15-070).

For Internal Use Only: ☐ **Approved** ☐ **Disapproved** ☐ **Unable**

Date: Signature:

EMPLOYABILITY ASSESSMENT FORM
INSTRUCTIONS FOR THE SELF-INSURER

Purpose:

Rule requires the self-insurer to submit an Employability Assessment Report (EAR) no later than paying 90 days of continuous time loss after the filing or re-opening of the claim and if a vocational referral is not being made or if an extension of time is not necessary.

The primary purpose of the self-insurer's EAR is to notify the Department of an injured worker's employability status. **Objective reasons for the determination must be provided.**

DETERMINATION INFORMATION REQUIREMENTS:

The following lists what supporting documentation is required with the EAR.

Determination:	Information Requirement:
A. Eligible for vocational services	Employability Assessment Report
B. Able to work	
1. Return to Work (Currently working in similar work pattern as the time of injury)	
Priority Codes Definitions	
a. Return to the previous job with the same employer,	Full duty work release or job analysis signed by a physician or majority of medical opinion.
b. Modification of the previous job with the same employer including transitional return to work,	
c. A new job with the same employer in keeping with any limitations or restrictions,	
d. Modification of a new job with the same employer including transitional return to work,	
e. Modification of the previous job with a new employer,	Job analysis signed by a physician, majority of medical opinion or any other substantive documentation.
f. A new job with a new employer or self-employment based upon transferable skills,	
g. Modification of a new job with a new employer,	
h. A new job with a new employer or self-employment involving on-the-job training,	
i. Short-term retraining and job placement.	
2. Worker can work based on transferable skills or has full duty release but is not working.	Employability Statement Form (ESF) and Claim File
C. Not eligible for vocational services	
1. Pre-existing and progressive condition(s)/unrelated	Appropriate Expert Opinion & Claim File for each category
2. Post condition(s)/unrelated	
3. Direct effects of the industrial injury	
4. Combined effects (second injury)	
5. Worker's actions	Supporting documentation for a long term pattern of minimal compliant behavior

NOTE:
It is the responsibility of the Employer or Service Company to submit the EAR and any attachments, including the ESF, to the Department with copies to the injured worker.