Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

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

Request for Claim Information

For the worker or worker's representative Or the employer or the employer's representative

This form must be completed in full. Copies of documents are a chargeable item.

Claim Number
Worker's Name

Name of Person Making Request	I am: ☐ Worker ☐ Other	
Address		
City	State	Zip Code

☐ I am requesting my claim file.

☐ I am requesting the following information from my claim file (*for example, "the panel exam of February 4, 2013" etc.* please let 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. My authorization is:

☐ On file ☐ Attached

☐ I am the employer or employer's representative requesting the claim file for the worker name 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

Date

For Department Use Only:

Action taken on request:		
Name of person taking action:	Date action taken:	Section/Office