Employer Report of Industrial Injury or Occupational Disease

Employer: Complete this form online at http://www.waretailservices.com/report-a-claim/

1. Name and title of person completing this form:	2. Employee Name:	3. Claim Number:
4. Name of Business:	5. Employee's Social Security Number: Last four only: XXX-XX-	6. Employee's job title:
7. Business mailing address:	8. Date of injury *or last occupational exposure:* ☐ Known ☐ Unknown Date:	9. Date Reported: ☐ Known ☐ Unknown Date:
		10. Time reported: ☐Known ☐Unknown Time: ☐am ☐pm
11. Business location (if different from mailing address)	12. Describe in detail how the incident occurred?	
13. Business phone number:	14. Was this incident caused by failure of a machine or product OR someone who is not an employee? ☐Yes ☐No ☐Possibly	
15. UBI #:	16. Body part(s) injured or exposed – include side of body:	
17. L&I Account ID # :		
18. Employee's risk class code:	19. Do you question the validity of this claim? ☐Yes ☐No	
20. Employee is: ☐ Owner ☐ Partner ☐Volunteer ☐ Corp ☐ shareholder/director/officer ☐ Optional L&I Coverage Elected ☐ None of the above	21. Employer comments or concerns about this claim:	
22. Does your business have a maritime function ☐Yes ☐ No	23. Were you contributing to this worker and/or family's health care benefits (medical, dental, and/or vision insurance) on the date of injury? ☐Yes ☐ No	
24. Rate of pay (list amount) ☐ hour ☐ day ☐ week ☐ month ☐ other: Hours per day Days per week	25. How much did you pay for medical, dental and vision coverage? (list amount) Per: ☐ hour ☐day ☐week ☐ month ☐other:	
	26. Date medical, dental and vision coverage ends:	
27. Average daily earnings from: ☐ piecework ☐ tips ☐ commissions (list amount):	28. Is temporary light duty work available during recovery? ☐ Yes ☐ No Has the job of injury been modified to accommodate restrictions from the Activity Prescription Form? ☐ Yes ☐ No	
29. All bonuses paid 12 months prior to injury? (List Amount)		
30. Did the employee miss any time from work? ☐ Yes ☐ No If Yes, the employee missed work starting on: and returned to work on:	31. Who can we contact about light duty return to work information for the employee? Name: Phone: Email	
32. Do you pay wages/salary if the employee is off work? ☐ Yes* ☐ No If yes type of pay: ☐ regular wages/salary ☐ paid time off ☐ vacation ☐ sick ☐ contractual Other: **Kept on Salary (wage replacement benefits) excludes vacation pay, sick leave, holiday pay, paid time off or similar types of compensation.*	33. List any witnesses: Name: Phone: Name: Phone:	
	34. Did the employee die? ☐ Yes ☐ No	
	35. I declare these statements to be true to the best if my knowledge and belief. I acknowledge that by typing my name below, I am digitally signing this document. Signature: Date:	

RETAIL ASSOCIATION SERVICES Inc.

Complete online at http://waretailservices.com or fax completed form to 888-512-1676. Mail to: Washington Retail Association P.O. Box 2227, Olympia, WA 98507-2227

Or email to: admin@waretailservices.com

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