Washington State Department of Labor & Industries

Notice to Employees

It's the law! Employers must post this notice where employees can read it
(Revised Code of Washington 51.14.100).

If a job injury occurs

Your employer is self-insured. You are entitled to all of the benefits required by the state of Washington's workers' compensation (industrial insurance) laws. These benefits include medical treatment and partial wage replacement if your work-related injury or disease requires you to miss work. Compliance with these laws is regulated by the Department of Labor & Industries (L&I).

What you should do

Report your injury. If you are injured, no matter how minor the injury seems, contact the person listed on this poster.

Get medical care. The first time you see a doctor, you may choose any health-care provider who is qualified to treat your injury. For ongoing care, you must be treated by a doctor in the L&I medical network. (Find network providers at **www.FindADoc.Lni.wa.gov**.)

Qualified health-care providers include: medical, osteopathic, chiropractic, naturopathic and podiatric physicians; dentists; optometrists; ophthalmologists; physician assistants; and advanced registered nurse practitioners.

File your claim as soon as possible. For an on-the-job injury, you must file a claim with your employer within one year after the day the injury occurred. For an occupational disease, you must file a claim within two years following the date you are advised by a health-care provider in writing that your condition is work related.

To report an injury:

If you should become injured on the job or develop an occupational disease, immediately report your injury or condition to the person designated below:

Name: _____

Phone: _____

For additional information or help with a workers' compensation issue you can contact the Ombudsman for Self-Insured Injured Workers at 1-888-317-0493.

Other formats for persons with disabilities are available on request. Call 1-800-547-8367. TDD users, call 360-902-5797. L&I is an equal opportunity employer.

About required workplace posters
*Go to **www.Posters.Lni.wa.gov** to learn more about workplace posters from L&I and other government agencies.*

Self-Insurance Section
Department of Labor & Industries
P.O. Box 44890
Olympia WA 98504-4890

PUBLICATION F207-037-909 [12-2012]

On the Web: www.Lni.wa.gov

Washington State Department of Labor & Industries

Aviso a los empleados

¡Es la ley! Los empleadores deben colocar este aviso en un lugar donde puedan leerlo los empleados.
(Código Revisado de Washington 51.14.100).

Si ocurre una lesión en el trabajo

Su empleador está autoasegurado. Usted tiene derecho a todos los beneficios requeridos por las leyes de compensación para los trabajadores (seguro industrial) del estado de Washington. Estos beneficios incluyen tratamiento médico y sustitución parcial de su salario si no puede trabajar como resultado de su lesión o enfermedad. El cumplimiento de estas leyes está regulado por el Departamento de Labor & Industrias (L&I).

Lo que usted debe hacer

Reporte su lesión. Si usted se lesiona, aún cuando la lesión parezca ser minima, comuníquese con la persona indicada en este cartel.

Obtenga atención médica. La primera vez que usted visite a un doctor, usted puede escoger a cualquier proveedor de cuidado de la salud que esté calificado para tratar su lesión. Para cuidado continuo, usted debe recibir tratamiento de un doctor de la red de proveedores médicos de L&I. (Encuentre proveedores de la red en **www.Lni.wa.gov/Spanish/ClaimsIns/Claims/FindaDoc**.)

Los proveedores de cuidado de la salud calificados incluyen: médicos generales, osteópatas, quiroprácticos, médicos de naturopatía y podiatría, dentistas, optometristas, oftalmólogos, asistentes de doctor y enfermeras registradas de práctica avanzada.

Presente su reclamo lo más pronto posible. Para una lesión en el lugar de trabajo, usted tiene que presentar un reclamo con su empleador dentro de un año a partir de la fecha en que ocurrió la lesión. Para una enfermedad ocupacional, usted tiene que presentar un reclamo dentro de dos años después de la fecha en la que un proveedor de cuidado de la salud le haya notificado por escrito que su condición está relacionada con su trabajo.

Para reportar una lesión:

Si sufre una lesión en el trabajo o se le presenta una enfermedad ocupacional, repórtelo inmediatamente a la persona indicada abajo:

Nombre: _____

Teléfono: _____

Para información adicional o ayuda con un asunto relacionado con la compensación para los trabajadores, se puede comunicar con el Ombudsman (defensor) de la sección de trabajadores lesionados autoasegurados al 1-888-317-0493.

A petición del cliente, hay otros formatos disponibles para personas con discapacidades. Llame al 1-800-547-8367. Usuarios de TDD llamen al 360-902-5797. L&I es un empleador con igualdad de oportunidad.

Información sobre los carteles requeridos en el lugar de trabajo
*Vaya a **www.Lni.wa.gov/IPUB/101-054-999.asp** para aprender más sobre los carteles del lugar de trabajo de L&I y de otras agencias gubernamentales.*

Self-Insurance Section
Department of Labor & Industries
PO Box 44890
Olympia, WA 98504-4890

PUBLICACIÓN F207-037-909 [12-2012]

En Internet: www.Lni.wa.gov

WASHINGTON WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

Employer's First Report of Injury (FROI)

This form, numbered FORM IA-1, must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, FROI's can be submitted online at www.berkindcomp.com. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records).

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the First Report of Injury. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

Wage Statement

An average weekly wage must be established on any case where it is anticipated that the injured employee might lose work beyond the waiting period of three (3) days. The daily wage and number of days regularly employed is needed to determine the average weekly wage. We may inquire about wages for a similar employee of the same class and grade. Remember computation of wages may include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee if they constitute a financial benefit to the employee and are capable of monetary calculation. If there are weeks with no wages, please explain the reason by coding as follows:
V= Vacation I= Illness L= Lay off P= Personal leave O= Other
If you have any questions, feel free to contact the claim department to assist you.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

Mandatory Poster

The Division of Workers' Compensation poster must be displayed in your personnel office (if there is one) and in prominent places where employees will see it.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

M MALE
F FEMALE
U UNKNOWN

MARITAL STATUS

U UNMARRIED SINGLE/DIVORCED
M MARRIED
S SEPARATED
K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT

0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
2 MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED > 24 HOURS
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		