(Select one) Language Preference
☐ English ☐ Spanish ☐ Russian ☐ Korean
☐ Chinese Simplified ☐ Chinese Traditional ☐ Vietnamese
☐ Laotian ☐ Cambodian ☐ Other _____

PROVIDER'S INITIAL REPORT

MAIL TO SELF-INSURED COMPANY

A Provider's Initial Report (PIR) completed by the provider and the worker, establishes a claim. When the completed PIR is received by the employer, they must assign a claim number and adjudicate the claim.

1.CLAIM NUMBER

1. NAME OF SELF-INSURED EMPLOYER
Catholic Archbishop of Seattle

ADDRESS
710 9th Avenue

CITY: Seattle | STATE: WA | ZIP: 98104

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE
Sedgwick Claims Mgmt

ADDRESS
PO Box 14518

CITY: Lexington | STATE: KY | ZIP: 40512

EMPLOYER'S TELEPHONE NUMBER

EMPLOYER'S SERVICE REP PHONE
866 471 9518

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST

3. WORKER'S TELEPHONE NO.

4. MAILING ADDRESS

5. SOCIAL SECURITY NUMBER

6. CITY | STATE | ZIP

7. DATE OF BIRTH

8. INJURY DATE | 9. TIME | ☐ AM ☐ PM

10. Have you missed work due to your injury? If so, what dates were you off?
From: To:

11. SEX

12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS

12B. NUMBER OF DEPENDENTS

13. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider – **START HERE**

3. This exam date

4. Date patient first seen by you for this injury/condition

a. ICD Dx CODES	b. Diagnosis – specify Right/Left

14. MEDICAL RELEASE AUTHORIZATION: PURSUANT TO RCW 51.36.060, I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY RELEVANT MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.

Worker's Signature Date

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, Specify

15. I have read the statement of Responsibility and the Legal Notice on the next page of this form.
Worker's Signature Date

6. Referred for Diagnostic Studies
☐ No ☐ Yes, Specify

9. a. Has the worker ever been treated for the same or similar condition? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

b. Is there any pre-existing impairment of the injured area? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

c. Are there any conditions that will prevent or retard recovery? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

d. Was the diagnosed condition caused by this work injury or exposure on a more probable than not basis? (check one)
Yes ☐ Probably (51% or more) ☐
No ☐ Possibly (Less than 50%) ☐

7. Treatment Recommendations

10. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?
Lifting Bending
Standing Sitting
Other

d. If not released, how many days off work due to the work injury?

8. Did you refer the patient to an L&I medical network provider for follow-up?
☐ YES ☐ NO Referred to:
Address
Phone

Licensed Healthcare Provider must sign before report is accepted
11. Signature

12. Phone | 13. Date

14. Attending Healthcare Provider Name

15. Address

City | State | ZIP

16. L&I Provider Number or NPI | 17. IRS Account #

DO NOT SEND THIS FORM TO

LABOR & INDUSTRIES

WEB ADDRESS TO CHECK FOR UPDATES OF FORM:
www.Lni.wa.gov/go/F207-028-000

NOTE: Beginning Jan. 1, 2013, injured workers will need to get ongoing care from a medical provider who is part of the L&I Medical Provider Network. They may see a non-network provider for the initial visit, but for additional or ongoing care, they will need to transfer to a network provider.

MAIL TO SELF-INSURED COMPANY

1. If the worker brings this form to your office, this box may be pre-printed. If you initiate the form in your office, obtain information from the worker.

2. Have the worker complete this box or obtain information from the worker.

ATTENDING HEALTH CARE PROVIDER INFORMATION

NOTICE: FAILURE TO FILE THIS REPORT WITHIN 5 DAYS FROM THE DATE OF TREATMENT MAY RESULT IN A PENALTY OF $500 IN ACCORDANCE WITH RCW 51.48.060.

3. This exam date.

4. Date you first treated patient for this injury/condition.
   a) Insert ICD Dx coding which corresponds to narrative diagnosis in Box 3b.

   b) Please list all diagnoses of conditions present which are result of incident or exposure. Also specify which side of body (right/left).

5. Indicate "Yes" or "No". If "Yes", list objective findings which support diagnosis. Do not restate diagnosis.

6. Indicate "Yes" or "No". If "Yes", specify study and complete findings if known.

7. Indicate treatment recommendations.

8. Specify name, address and phone number of health care provider to whom referred. Treatment beyond the initial visit must be done by providers enrolled in Washington's workers compensation medical provider network. (This applies to workers of Self-Insured and State Fund employers.) Information to enroll in the network is available at JointheNetwork@Lni.wa.gov. If you choose not to enroll and your patient needs additional treatment, refer him or her to a network provider. The provider directory is available at www.Lni.wa.gov.

9. Indicate "Yes" or "No" and provide the additional information requested.

10. Indicate "Yes" or "No" and provide the additional information requested.

11. Signature of health care provider providing treatment and completing form.

12. Health care provider's phone number.

13. Date health care provider signs report

14. Print or type your name as it appears on your Department of Labor and Industries payee account.

15. Indicate your full mailing address.

16. Indicate your Department of Labor and Industries issued provider number or NPI.

17. Provide your Internal Revenue Service reporting account number.

PATIENT INFORMATION

1. Leave blank.

2. Name of injured worker.

3. Worker's phone number.

4. Worker's mailing address or street address.

5. Worker's social security number.

6. City, state and ZIP code of worker's address.

7. Date worker was born.

8. Date accident occurred.

9. Time accident occurred.

10. Dates the worker missed work due to this injury.

11. Indicate -- M = Male F = Female

12A. Marital/Registered Domestic Partnership Status, e.g., M = Married, S = Single, D = Divorced, DP = Registered Domestic Partnership.

12B. Dependents -Number of dependents under age 18 (does not include spouse/domestic partner).

13. Brief description of accident or exposure by worker.

14. Medical Release Authorization. Worker's signature authorizes the release of relevant medical information.

15. Statement of Responsibility - I have reported or will report this incident or exposure to my employer. If my claim is denied, I understand that I will be responsible for the care provided to me.

16. LEGAL NOTICE --RCW 51.48.020 (2) PROVIDES: ANY PERSON CLAIMING BENEFITS UNDER THIS TITLE WHO KNOWINGLY GIVES FALSE INFORMATION REQUIRED IN ANY CLAIM OR APPLICATION UNDER THIS TITLE SHALL BE GUILTY OF A FELONY, OR A GROSS MISDEMEANOR.