(Select one) Language Preference

☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese
☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other ______

MAIL TO SELF-INSURED COMPANY

PROVIDER'S INITIAL REPORT

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
King County Safety and Claims

ADDRESS
500 - 4th Avenue Suite 500

CITY	STATE	ZIP
Seattle	WA	98104

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE
King County Safety and Claims

ADDRESS
500 - 4th Avenue Suite 500

CITY	STATE	ZIP
Seattle	WA	98104

EMPLOYER'S TELEPHONE NUMBER	EMPLOYER'S SERVICE REP PHONE
206-477-3350	206-477-3350

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 the injury? If so, what date did you stop work?
11. SEX
12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS
12B. NUMBER OF DEPENDENTS
13. Describe in detail how your injury or exposure occurred:

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

15. I have read the statement of responsibility in the Legal Notice on the reverse of this form.
Worker's Signature Date

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

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, [illegible]

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

7. Treatment recommendation

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

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) ☐
Possibly (less than 50%) ☐

10. a. Have you released the worker to return to regular work?
No ☐ Yes ☐ effective date of return to work
b. Have you released the worker to return to light duty?
No ☐ Yes ☐ effective date of return to

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?

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

Distribution: Original-Employer, Copy-Worker, Copy–Provider 01-2014 version
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INFORMATION ONLY
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