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| http://inside.lni.wa.gov/Director/resources/GraphicIdentity/BlackPrint.png**Mail or fax completed forms to:**PO Box 44291Olympia WA 98504-4291Or fax to: 360-902-4567 | **Preferred Worker Request** |
| Worker’s Name      | Claim Number      |
| Job of Injury Title      |

**A. Request preferred worker status for injured worker**

(Vocational providers often complete this section. Not a voc provider and need help? Call your VRC or 800-845-2634).

**Requirements injured worker must meet for preferred worker\* status.** (State Fund workers only)

|  |  |
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| **1.** | **The worker’s health care provider has permanently restricted the worker from returning to the work they were doing at the time of the injury.** |
|  | Attach ***one*** of the following required documents: |
|  | [ ]  | A completed and signed [Job Analysis](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2398) or [Employer’s Job Description](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1684) for the job of injury showing the worker’s health care provider’s **permanent** disapproval. |
|  | [ ]  | Medical information in the claim file clearly indicating that the worker is **permanently** restricted from performing the job of injury and specifying which duties the worker is unable to do. |
| **2.** | **The work restrictions given by the health care provider are supported by medical findings related to the accepted condition.** |
|  | Attach this required document: |
|  | [ ]  | Chart note or Independent Medical Exam (IME) containing medical findings related to accepted medical condition in claim (Large volumes of information are unnecessary.) |
| **3.** | **Further recovery is not expected, due the worker’s permanent loss of physical or mental function related to the accepted condition.** |
|  | Attach this required document: |
|  | [ ]  | Chart note, Activity Prescription Form (APF), or IME indicating the worker has either: |
|  |  | * Completed treatment
 |
|  |  | OR |
|  |  | * Is at or near maximum medical improvement.
 |

**Submitted by**

|  |  |  |
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|       |  |       |
| Print name of person submitted packet |  | If not worker, print job title and business or firm name |

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|       |  |       |
| VRC provider number (if applicable) |  | Phone number |

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|       |  |       |
| VRC ID number (if applicable) |  | VRC firm provider number (if applicable) |

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|  |  |       |
| Submitter’s Signature (required) |  | Date (required) |

**B. Request approval of preferred worker job**

(Hiring employer completes this section. Need help? Call your VRC or the phone number below.)

|  |  |
| --- | --- |
| Hiring employer’s business name      | L&I account number      |
| Employer’s mailing address      |
| City      | State      | Zip Code      |
| Phone number      | Fax number      |
| Worker’s new job title      | Date of hire / Start date      |

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| * Does this worker currently have preferred worker status?
 |
|  | [ ]  Yes [ ]  No (*If ‘No’, apply on Part A of this form*) |
| * Did the worker’s health care provider approve the job and find it within the worker’s documented medical restrictions?
 |
|  | [ ]  Yes [ ]  No |
| * Are you (the employer) in good standing with L&I?
 |
|  | [ ]  Yes [ ]  No (To check, go to: [www.Lni.wa.gov/Verify](http://www.Lni.wa.gov/Verify))  |
| * Are you (the employer) ‘self-insured’ for workers’ compensation coverage in Washington?
 |
|  | [ ]  Yes [ ]  No Not sure what self-insurance is? Go to [www.Lni.wa.gov/SelfInsurance](http://www.lni.wa.gov/SelfInsurance)  |
|  | If you answered ‘yes’ to the above question, was the worker certified as a preferred worker under a State Fund claim on or after January 1, 2016? |
|  | [ ]  Yes [ ]  No  |

**Required Attachments**

|  |  |
| --- | --- |
| [ ]  | [Job Analysis](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2398) or [Employer’s Job Description](http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1684) ― approved by the health care provider and consistent with work restrictions in the worker’s L&I claim file. |
| [ ]  | Formal job offer signed by the worker and employer. |

**Sign below to certify that the information on this form is true and accurate to the best of your knowledge.**

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|       |  |       |
| Printed name of employer  |  | Title |

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|  |  |       |
| Employer’s signature (required of hiring employer) |  | Date (required) |

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|       |  |       |
| Printed name of person submitting packet |  | Print job title and business or firm name |

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|  |  |       |       |
| Submitter’s signature (required) |  | Date (required) | Phone number |

*\*For more information about the Preferred Worker Program, go to* [*www.Lni.wa.gov/PreferredWorker*](http://www.lni.wa.gov/ClaimsIns/Voc/BackToWork/PrefWkr/Default.asp)

***Important: New*** *eligibility requirements began on January 1, 2016. To view online, search* [*RCW 51.32.095(4)*](http://app.leg.wa.gov/rcw/default.aspx?cite=51.32.095)