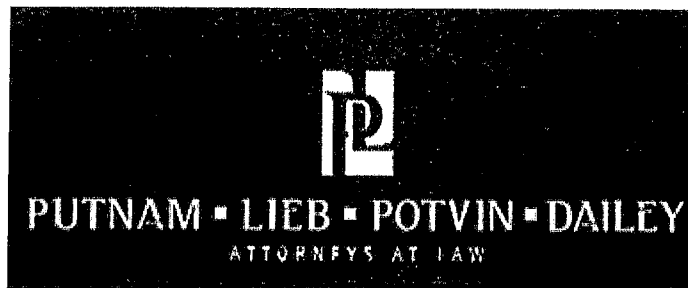


**Claim Status:**

- ☐ Open  
☐ Closed, Date: \_\_\_\_\_  
☐ Rejected, Date: \_\_\_\_\_  
☐ Appealed to Board of  
 Industrial Insurance  
 Appeals



Claim No.: \_\_\_\_\_

Injury Date: \_\_\_\_\_

**WORKER COMPENSATION INTERVIEW FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Can we text you with important messages? ☐ Yes ☐ No Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ No. of Dependents at home or in college: \_\_\_\_\_

May we speak to your spouse about the case? ☐ Yes ☐ No

What are your injuries (body part / psychological diagnosis)? \_\_\_\_\_

How did your injury happen? \_\_\_\_\_

Who are your doctors? \_\_\_\_\_

What type of treatment have you received? (check all that apply)

☐ Physical Therapy ☐ Chiropractic ☐ Surgery ☐ Injections ☐ Physical Capacities Exam
Has the State or employer sent you to any doctors (Independent Medical Exam)? ☐ Yes ☐ No

Employer at time of injury: \_\_\_\_\_ Since? \_\_\_\_\_

Position at time of injury: \_\_\_\_\_ ☐ Full Time ☐ Part Time ☐ SeasonalMonthly salary or hourly rate? \_\_\_\_\_ Overtime? ☐ Yes ☐ No Bonus? ☐ Yes ☐ NoOn the injury date were you covered by the employer's healthcare plan? ☐ Yes ☐ NoDate Coverage Ended: \_\_\_\_\_ Did you have a second job? ☐ Yes ☐ NoAre you presently working? ☐ Full Duty ☐ Modified Duty ☐ Reduced Hours ☐ No, date last worked: \_\_\_\_\_Any prior worker compensation claims? ☐ Yes ☐ No

What is your highest level of education? \_\_\_\_\_

What kinds of work have you done over your lifetime? \_\_\_\_\_

Are you receiving any of the following social services benefits? (check all that apply)

☐ Social Security ☐ Unemployment ☐ DSHS ☐ None

Client Signature \_\_\_\_\_

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 Wayne Lieb  
 Kathryn Potvin  
 Dustin J. Dailey  
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**AUTHORIZATION FOR FILE REVIEW AND ACCESS TO CLAIM AND ACCOUNT CENTER**

**TO WHOM IT MAY CONCERN:**

I hereby request that the law firm of PUTNAM LIEB POTVIN, be furnished with a complete copy of my claim file, as set out below, for their inspection and review. The term "file" includes, but is not limited to, all files and information regardless of where they are located, how they are maintained and, whether they are oral, paper, electronic or any other medium, including:

- All medical records and treatment bills
- All vocational records and vocational bills
- All correspondence.
- All computer notes.
- Time Loss/LEP payment logs and receipts
- All information regardless of whether it is recorded, regarding telephone conversations.
- All information given to the Department of Labor and Industries on this claim
- All oral information.
- Copies of all photographs, films, videotape, surveillance information, etc.

In addition to the above, please forward a copy of (or provide electronic access to) the following files:

- R-Log
- LINIIS Report
- MIPS
- PROF Notes

**This release is specifically extended to include access, electronic or otherwise, to claim files containing any and all instances of actual or suspected exposure to blood borne pathogens.**

I hereby request that you specifically identify any documents or information not being provided and the reason that they are not being provided, whether they have been requested or not.

**CLAIM AND ACCOUNT CENTER:** I further request that Putnam Lieb be given access to view my claims file until further notice on the Claim and Account Center website.

**APPLICATION TO PRIOR AND CONCURRENT CLAIMS:** This authorization shall extend to the claim identified below and all prior and concurrent Washington worker compensation claims.

**REVOCATION OF ELECTRONIC MAIL SERVICE:** If an option has been selected for electronic mail, that option is revoked. All future correspondence shall be mailed to my attorneys.

**GENERAL PROTEST:** We hereby PROTEST any adverse written decisions or orders.

\_\_\_\_\_  
Claimant Printed Name

\_\_\_\_\_  
Claimant Signature

\_\_\_\_\_  
Claim No(s).

\_\_\_\_\_  
Date

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