IPENSER
North America, Inc.
Claims Administration-Risk Management-Consulting
1802 Terminal Drive
Richland, WA 99354

Work Status Form

- *Complete this form within 14 days each time you receive it.*
- *Read the instructions on the back before completing the form.*
- *Failure to return this form may cause benefit payment delays.*

Claim number
Date of request
Date of injury

Your work status:

☐ I didn't miss **any** work due to my work-related injury and/or disease.

☐ I'm **not** working and remain unable to work at **any** employment due to my work-related injury and/or disease since

|_|_| – |_|_| – |_|_|

This was the first complete day I didn't do **any** type of work – paid or unpaid – such as volunteer activities, self-employment, or caregiving services (COPES).

I returned to work on |_|_| – |_|_| – |_|_| **with** ☐ **employer of injury** ☐ **new employer** ☐ **self-employment.**

Self-employment includes but is not limited to licensed, unlicensed, and/or online business.

I'm now working:

☐ Regular hours ☐ Reduced hours

☐ Regular wages ☐ Reduced wages

Before returning to work, I didn't work at any employment due to my work related injury and/or disease from |_|_| – |_|_| – |_|_| **through** |_|_| – |_|_| – |_|_|

This includes any type of work – paid or unpaid – such as volunteer activities, self-employment or caregiving services (COPES).

I have applied for and/or received the following benefits:

☐ Yes ☐ No Unemployment
☐ Yes ☐ No Social Security
☐ Yes ☐ No Retirement
☐ Yes ☐ No Monetary assistance from another government agency

On the day I was injured, my employer was paying for and/or providing the following:

☐ Yes ☐ No Medical/Dental/Vision
☐ Yes ☐ No Housing
☐ Yes ☐ No Board
☐ Yes ☐ No Utilities/Fuel
☐ Yes ☐ No I am still receiving these benefits. If no, the last date covered: |_|_| – |_|_| – |_|_|

Has the legal custody of your dependent(s) changed? ☐ Yes ☐ No

Has your address or phone number changed? If so, write your new address or phone number below.

Name:	
Street address:	
City, state, zip code:	
Phone number:	

Your signature is required below.

By signing below, I certify that the information I am providing is true and correct.. I understand that I must immediately notify my claim manager if my doctor releases me for any work, if I am incarcerated and under sentence, or if the custody of my children changes. I also understand that if on this form I intentionally make a false statement or fail to disclose information about my physical condition, ability to work, and/or work performed (paid or unpaid), I will be required to refund any benefits wrongfully obtained and I may be subject to civil and/or criminal penalties.

Worker name (please print) | Worker signature | Best contact phone number | Date

Work Status Form Instructions

This form is for payment of time loss compensation if you didn't work and are unable to work during the dates you indicate. It's important you read this form carefully and complete all sections that apply to you.

Minimum requirements for payment of time loss compensation:
- Medical certification from your attending provider with objective medical findings and restrictions.
- A Work Status Form which you complete to request benefits. You must complete this form each time you receive it.

Your work status:
- We need to know if you missed time from **any** work due to your injury.
- It's important to notify Colville Confederated Tribes if you're engaged in activity that includes, but isn't limited to volunteer work, self-employment or caregiving.
    - Volunteer work could include Red Cross, food bank, soup kitchen helper, coaching sports.
    - Self-employment could include online sales, photography, selling firewood, newspaper delivery.
    - Caregiving could include caring for disabled family, babysitting, COPES/DSHS (paid caregiving).

Return to Work:
- If you haven't returned to work, skip this section.
- If you returned to any type of work, complete this section.
    - This could include working for a different employer, self-employment or volunteer activities.
- If you missed time from **any** work, specify the dates you didn't work.
    - The start date is the first day you didn't work in any capacity.
    - The end date is the day before you returned to work.

- If you're working with reduced hours or wages, you may qualify for Loss of Earning Power benefits. Please provide your Claims Examiner with copies of your timecard.

Other benefits:
- If you have applied for, or are receiving retirement, social security, etc., this may affect your time loss benefits.
- Monetary assistance from another government agency could include DSHS TANF.

Employer provided benefits on the date of injury:
- This information is needed to determine the current status of the employer benefits provided to you on the date of injury. For example, this could include your employer contribution to health care benefits.
- If you aren't continuing to receive the benefit(s), your time loss compensation amount may be affected.

Custody of dependents:
- Your dependent's portion of time loss compensation must be paid to the legal custodian.
- If the custody changes, L&I will need a copy of the legal paperwork and the current address for the legal custodian.

Change of address:
- If your address has changed, please provide your new address here.
- If not, leave this section blank.

Signature:
- Your signature is required for consideration of time loss benefits.
- By signing this form you're confirming the information you've provided is correct.