



Claims Suppression Complaint Form

Case Number (Dept. Use Only)

Worker Information (Anyone may assist the worker in completing this form and in filing a complaint.)

Worker's Full Name		Date
Present Address		Phone Number
City	State	Zip Code
Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your preferred language for all communications with Labor and Industries?	
What is your preferred method of communication? <input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email		Current Email Address
Were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury Claim Number (if applicable)	Date of Injury (if applicable)
Did you miss work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Still off work	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has employment been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you still under medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Medical Provider	Date alleged act of claim suppression occurred

Attorney Information

(Complete this section if you have an attorney or if you are an attorney filing this complaint.)

Do you have any attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Attorney Name	Phone Number
Attorney Address	City State Zip Code

Employer Information

Employer	Business Name (if different)
Type of Business	Business Phone Number
Supervisor's Name	Date Hired
Department Where You Worked	Job Title
Business Address	
Business Address	City State Zip Code

Continue to next page

What did your employer say or do to keep you from filing a workers' compensation claim?

If there any witnesses to the employer's actions, list their names and how to contact them.

Have you filed your complaint with any other agency? Yes No

If yes, which agency/agencies have you contacted?

I certify under the penalties of perjury that the information provided herein is the truth to the best of my knowledge.

Print Name

Signature

Date

Mail completed form to: Department of Labor and Industries
Investigations
PO Box 44277
Olympia WA 98504-4277

No employer shall engage in claim suppression by inducing employees to fail to report injuries; inducing employees to treat injuries in the course of employment as off-the-job injuries; or acting otherwise to suppress legitimate industrial insurance claims.

Claim suppression does not include bona fide workplace safety and accident prevention programs or an employer's provision at the worksite of first aid as defined by the Department of Labor & Industries.

If the director determines that an employer has engaged in claim suppression and, as a result, the worker has not filed a claim for industrial insurance benefits as prescribed by law, then the director in his or her sole discretion may waive the time limits for filing a claim provided in [RCW 51.28.050](#), if the complaint or allegation of claim suppression is received within two years of the worker's accident or exposure. For the director to exercise this discretion, the claim must be filed with the department within ninety days of the date the determination of claim suppression is issued.

[RCW 51.28.050](#): No application shall be valid or claim thereunder enforceable unless filed within one year after the day upon which the injury occurred or the rights of dependents or beneficiaries accrued, except as provided in [RCW 51.28.055](#) and [51.28.025\(5\)](#).