Washington State Department of Labor & Industries

Workers' Compensation Claims Suppression Complaint Form

Investigations
PO Box 44277
Olympia WA 98504-4277

Questions?
Call 1-866-324-3310 or 360-902-9155
Email: CSIIIDComplaints@Lni.wa.gov

Case Number (Dept. Use Only)

No employer shall engage in claim suppression by inducing employees to fail to report injuries; including 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 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).

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? ☐ Yes ☐ No	What is your preferred language for all communications with Labor & Industries?		
Were you injured? ☐ Yes ☐ No	Injury Claim Number (if applicable)		Date of Injury (if applicable)
Did you miss work? ☐ Yes ☐ No	Have you returned to work? ☐ Yes ☐ No		Has employment been terminated? ☐ Yes ☐ No
Are you still under medical care? ☐ Yes ☐ 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 an attorney? ☐ Yes ☐ No			
Attorney's Name	Attorney's Phone Number		
Attorney's 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 Line 2	City State Zip Code

What did your employer say or do to keep you from filing a workers' compensation claim? If you need more space, attach additional pages.

If there were any witnesses to the employer's actions, list their names, address, and phone numbers.

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

Or email to: CSIIIDComplaints@Lni.wa.gov

RESET