Washington State Department of Labor & Industries

Victim Verification Form

Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-44520
360-902-5355 or 800-762-3716

Claim Number	Date of request	Date of injury

Instructions: If you are unable to work due to an injury received as a result of a crime and your employer is not paying your full wages, please complete this form in full, sign and send to the address above within 14 days. The form must be received in order to determine benefits.

Name		Phone Number
Address		
City	State	Zip Code

Victim's Statement

The statement below means that you did not perform any type of work – paid or unpaid – such as volunteer work, self-employment, COPES or CHORE Services. Do not include the last date worked in the date range of your statement below.

Due to my crime related injury/illness, I did not, and was not able to work from :

__________________ to __________________

Start Date End Date

This means you did not perform any type of work – paid or unpaid – such as volunteer work, self-employment, COPES or CHORE Services. Please do not include the last date worked in the date range above.

I will/did return to work on: __________ Hours per day: _____ Days per week: _____

Current wage is: $__________ ☐ Hour ☐ Day ☐ Week ☐ Month

I have applied for the following benefits:

	Date of application		Date of application
☐ None	__________	☐ Other public assistance	__________
☐ Unemployment	__________	☐ Social Security	__________
☐ Paid Family Leave	__________	☐ Retirement	__________

On the date of injury, your employer was paying for you and/or family any part of:

☐ Medical Insurance ☐ Dental Insurance ☐ Vision Insurance
☐ Housing/Board ☐ Fuel ☐ Utilities

Are you still receiving these? ☐ Yes ☐ No If yes, last date received: ____________

By signing below, I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and further that: I understand that if I make a false statement about my activities or physical condition, I will be required to refund my benefits and I may face civil or criminal penalties. I understand I must immediately notify my claim manager if I perform any work (paid or unpaid), if my doctor releases me for work, if I am incarcerated and under sentence, or if the custody of my children changes.

__________ ________________ __________________

Date Place Signature