Washington State Department of Labor & Industries

Stipulation for Claim Closure

This document is to be used only when both parties are represented.

Form Completed By: _____ Phone Number: _____ Date: _____

Claim Information:

Worker's Name: _____

Claim Number: _____ Date of Injury/Manifestation: _____

Time-loss paid through (date): _____ Total Days Paid: _____ Total Benefits Paid: $_____

LEP paid through (date): _____ Total Days Paid: _____ Total Benefits Paid: $_____

Attending Physician Name and Address: _____

_____

Claimant Representative: _____

Contact Name: _____ Phone Number: _____

Self-Insured Employer's Representative: _____

Contact Name: _____ Phone Number: _____

Date of Signed Agreement: _____

The parties agree the worker is at maximum medical improvement and the claim is ready to close with the following:

☐ Segregated condition(s):

☐ Accepted condition(s):

☐ Vocational/Ability to Work determination:

☐ Permanent Partial Disability:

☐ Other:

Required Attachments:

☐ Copy of signed stipulation pertaining to only the action(s) being requested.
☐ Medical documentation/declaration to support all aspects of the agreement.
☐ A completed SIF-2, if not previously submitted to the claim file.