Department of Labor and Industries PO Box 44324 Olympia WA 98504-4324 1-800-845-2634 or (360) 902-6763 TDD (360) 902-5797 FAX (360) 902-6706

WORKER'S SECTION

EMPLOYER'S SECTION



INTENT TO HIRE PREFERRED WORKER

Claim Number

EMPLOYERS:

Worker's Name

Worker Phone #

> To benefit from the Preferred Worker Program, you must send this form and the job description on the reverse **within 60 days** of the date of hire. The job description must show the physical requirements of the job you are offering. To expedite, fax to the number above.

Social Security Number

PW's Certification #

When you hire a Preferred Worker:										
injured You w Prefer of the premi You m Prefer	or contractill be exented Work Supplemental was for all the workers when the workers with the workers with the workers with the workers will be a contracted workers with the workers with the workers will be a contracted with the workers	ets an occu npt from pa ter during to ntal Pension Il other em the Departa r leaves you	ecount will not pational disease aying Accident the certification fund premium aployees. ment of Labor ur employ with	se during the case trund and Me no period. You ms for the Prefand Industries thin the certific	ertificatio dical Aid must repo ferred Wo	n period. Fund premiu ort hours and rker. You m next quarterly	ams for the l pay your pon nust still pay	rtion all		
Employer's Business Name				UBI (state tax #)		L&I Account Number				
Nature of Employer's Business						Paid OJT approved by L&I? Yes No				
Employer's Mailing Address						Employer's Phone #				
						Employer's FAX #				
Worker's job title					Date of Hi	re	Today's Date			
I intend to hire this Preferred Worker. I certify that I was not the employer at the time of injury and that I am not affiliated in any way with the employer at the time of injury. I also certify that the attached job description accurately represents the job duties this worker will be asked to perform. I will not ask this worker to perform any job duties or tasks that exceed the physical limitations or restrictions reported to me by the worker.										
Employer's Signature:			Employer's name (please print)							
L&I USE ON	ILY. 7204	cannot ex	tend beyond	the certificati	on period	end date or	n RPWO.			
	Approved? Yes		cation Period:			orker (Code 72		Date		
	□ No			Department of	`Labor & In	dustries Appro	val Signature			

Department of Labor and Industries Vocational Services FAX (360) 902-6706



PREFERRED WORKER EMPLOYER'S JOB DESCRIPTION

EMPLOYER: COMPLETE THIS FORM AND FAX TO (360) 902-6706

Job Title		Claim #		
Employer		 Claimant		
Phone #		Date	-	_
FIIOHE #				_
Description completed by:			Title	
	-		11tic	_
Essential task description:				
)	. 1 1			_
Machinery, tools, equipmen	t and personal	protective equipment:		_
	707		~	
		EMPLOYER USE ON		
	PH	HYSICAL DEMANDS		
N: Never (not at all)		F: Frequent (34%-66)		
S: Seldom (1-10% of the tire		C: Constant (67%-10	0 of the time)	
O: Occasional (11-33% of	the time)			
	Ewaguanay	D.	agazintian of Taglyg	
Sitting	Frequency	<u>D</u> (escription of Tasks	_
Standing				_
Walking				_
Driving				-
Lifting () lb.				_
Carrying: () lb.				-
Pushing/Pulling: () lb.				-
Climbing Stairs/Ladders				_
Bending/twisting at waist				_
Kneeling/squatting				_
Crouching/Kneeling				
Crawling				
Reaching above shoulder				
Repetitive Motion				
Handling/Grasping				
Fine Finger Manipulation				
Talking				
Hearing				
Seeing				_
Other:				

Employer: please include any Material Safety Data Sheets (MSDS)