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You can also electronically file by going to our web site at <http://www.biiia.wa.gov> and clicking on the e-Filing icon.

Board of Industrial Insurance Appeals  
PO Box 42401 Olympia, WA 98504-2401

## NOTICE OF APPEAL Washington State Workers' Compensation Appeal Only

If you disagree with a decision of the Department of Labor and Industries concerning a workers' compensation claim, this form can be used to file an appeal of that decision. You must file the appeal with the Board of Industrial Insurance Appeals, **WITHIN 60 DAYS of the date you received** the Department's decision. The appeal can be filed with the Board in person or by mail at the above address.

\*indicates required field

Today's date: \_\_\_\_\_:

Appeal filed by: \*  Self  Beneficiary  Provider  Employer  Lay Representative

Interpreter needed: Yes  No

Worker's Full Name: \* First \_\_\_\_\_ Middle Initial \_\_\_ Last: \* \_\_\_\_\_

Address: \* \_\_\_\_\_

City: \* \_\_\_\_\_ State: \* \_\_\_\_\_ Zip: \* \_\_\_\_\_

Work/Home Telephone: \* \_\_\_\_\_ Contact E-mail: \_\_\_\_\_

L&I Claim No: \* \_\_\_\_\_

I wish to appeal the decision of the Dept of Labor & Industries dated: \_\_\_\_\_ [copy attached]

The injury occurred (or occupational disease arose) on (Date) \_\_\_\_\_, at (Location) \_\_\_\_\_

Type of injury/disease: \_\_\_\_\_

What are you asking for? \* \_\_\_\_\_

I desire to have any proceedings held in: (City) \_\_\_\_\_

Employer at time of injury:

Address: \_\_\_\_\_

Business Mailing address of employer (main office)

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

(Signature) \* \_\_\_\_\_

Name: (Please Print) \* \_\_\_\_\_

It is important that the Board be able to reach you concerning your appeal. If you do not have a phone, please provide the number of a friend/relative where the Board can leave a message. Also, please notify the Board if you change your address.