STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

P.O. Box 44291 • Olympia, WA • 98504-4291

315

EL VALLE MARKETS INC
C/O ABC SERVICES NETWORK
PO BOX 448
EPHRATA WA 98823

Account No.
836,951-00
Risk Class
6402 00
Claim No.
BK87221
Worker
JOEY A CORRALES

November 17, 2023

2350106-000315-01-00000000

Dear Employer:

You have an employee who has filed a workers' compensation claim with us.

We need to hear from you. Your rates may be affected by this claim.

It's important for you to promptly:

1. Review the enclosed information we've received so far about this claim.
2. Complete the enclosed one-page form. Or, you may do this online: www.LNI.wa.gov/FileFast. We want to consider *your* information as well when we make important decisions on this claim.
3. Let us know if there is any incorrect information in the attached documents. Not your employee? Contact us right away so we can verify and clear any claim charges from your account.
4. Read the following page: "How you can keep your workers' comp costs under control."

Employers have the right to access claim files, including mental health information. An employer can only reveal mental health conditions or treatment to people who are authorized to access the information. RCW 51.28.070 helps protect the privacy of a claim file. All complaints regarding violations must be investigated. Find out more at: www.Lni.wa.gov/MentalHealthPrivacyWorker.

Questions? We are here to help and look forward to hearing from you as soon as possible.

MARIA PAULSON
Account Manager
360-902-5848
360-902-6690, Fax

Learn more at: **https://lni.wa.gov/claims/for-employers/help-your-employee-return-to-work**

Employer Report of Industrial Injury or Occupational Disease

Employer: We use your information for important decisions on this claim. Provide this information online at: **www.EmployerROA.Lni.wa.gov**, or fax the completed form to (360)902-6690, or mail to: Department of Labor & Industries, PO Box 44291, Olympia, WA 98504-4291

1. Name and title of person completing form	2. Employee JOEY A CORRALES	3. Claim number BK87221

4. Name of business	5. Employee's Social Security number	6. Employee's job title

7. Business mailing address	8. Date of injury *or last occupational exposure* ____/____/_____	9. Date reported ____/____/_____	10. Time reported AM PM
	11. Describe in detail how the incident occurred		
12. Business location (if different from mailing address)			

13. Business phone	14. Was this injury caused by a faulty machine or product or someone who is not your employee? ☐ Yes ☐ No ☐ Possibly
15. UBI:	16. Body part(s) injured or exposed - *include side of body*
17. L&I account ID:	
18. Employee's risk classification code:	19. Do you question the validity of this claim? ☐ Yes ☐ No
20. Employee is: ☐ owner ☐ partner ☐ volunteer ☐ corporate shareholder/director/officer ☐ optional L&I coverage elected ☐ none of the above	21. Employer comments or concerns about this claim.
22. Does business have a maritime function? ☐ Yes ☐ No	23. Were you contributing to this employee's and/or family's health care benefits (medical, dental and/or vision insurance) on date of injury? ☐ Yes ☐ No
24. Rate of pay: $_____ ☐ hour ☐ day ☐ week ☐ month ☐ other: Hours per day _____ Days per week _____	25. How much did you pay for medical, dental and vision coverage? $_____ Per: ☐ hour ☐ day ☐ week ☐ month ☐ other: 26. Date medical, dental, and vision coverage ends ____/____/_____
27. Average daily earnings from ☐ piecework ☐ tips or ☐ commissions $_____ 29. All bonuses paid 12 months prior to injury $_____	28. Is temporary light duty work available during recovery? ☐ Yes ☐ No
30. Employee missed time from work? ☐ Yes ☐ No Last date worked ____/____/_____ Date returned to work ____/____/_____	31. Who can we contact about light-duty return to work? Name: Phone: ( )
32. Do you pay wages/salary if employee is off work? ☐ Yes* ☐ No Type of pay: ☐ regular wages/salary ☐ paid time off ☐ vacation ☐ sick ☐ contractual ☐ other: **Kept on salary (wage replacement benefits) excludes vacation pay, sick leave, holiday pay, paid time off, or similar types of compensation.*	33. List any witnesses 34. Did the employee die? ☐ Yes ☐ No 35. I declare these statements to be true to the best of my knowledge and belief. X _____ Date _____

Complete online at **www.EmployerROA.Lni.wa.gov**
Or, fax completed form to **(360) 902-6690**, or mail to: **Department of Labor & Industries, PO Box 44291, Olympia, WA 98504-4291**

Please Review This Information and Keep for Your Records

Workers' Compensation Claim

Worker Information

Language preference: ENGLISH

Name	Sex	Social Security number	Home phone	Claim number
JOEY A CORRALES	MALE		(509) 830-1485	BK87221

Birth date	Home address	Height	Mailing address (if different from home address)	Family status
03/25/05	204 FAIRWAY PL SW MATTAWA WA 99349-1951	6 FT 0 IN Weight 247 LBS	SAME AS HOME ADDRESS	SINGLE

Dependent children Name	Legal custody	Birth date	Spouse or Registered Domestic Partner's name

Name and address of children's legal guardian	Date of injury	Time of injury	Shift
	11/11/23	8 PM	SWING

Body parts injured or exposed
RIGHT ARM

Description of how injury or exposure occurred
I WAS RESTOCKING BEER AND ONE OF THEM SHATTER AND CUT RIGHT ARM

Doing regular job?
YES

Where did the injury or exposure occur?
JOB SITE

Address where injury or exposure occurred
EL VALLE MARKET, INC
308 GOVERNMENT RD
MATTAWA WA 99349
GRANT COUNTY

Injury caused by a faulty machine, product or person other than employer or co-worker?
NO

Witnesses	Expected return to work date?	Date last worked?
EVELYN HERNANDEZ, TRISTETO		11/11/23

Incident reported to employer? Name and title of person reported to:	Date reported	Employer-paid health care benefits on day injured?
NO		

Business name of employer	Type of business
EL VALLE MARKETS, INC	

How long worked at business	Employer phone number	Employer address	Owner, partner, or officer?
9 MONTHS	(509) 932-4219	308 GOVERNMENT ROAD MATTAWA WA 99349	

Job title and duties
UKNOWN, BOX BOY

Rate of pay	Hours/day	Days/week

Additional earnings (daily average)	Number of paying jobs?
	MORE THAN 1

Signed?	Date of signature
NO	

(over)

Health Care Provider Information

Diagnosis
LACERATION R FOREARM

ICD Diag. Codes
S51.811A

Date first visit for this condition
11/13/23

Subjective complaints supporting diagnosis

Objective findings supporting diagnosis
LACERATION

Treatment and diagnostic testing recommendations
STERI STRIPS

Was the diagnosed condition caused by this injury or exposure?
YES

Will the condition cause the patient to miss work?
NO

Is there any pre-existing impairment of the injured area?
NO

Has the patient ever been treated for the same or similar condition?
NO

Are there any conditions that will prevent or slow recovery?
NO

Referral health care provider for follow-up

Name of hospital or clinic
REED CINDY L ARNP
MATTAWA COMMUNITY MEDICAL CLIN
215 1ST AVENUE
MATTAWA WA 99349-0112

Attending health care provider
CINDY REED
P O BOX 1581
MATTAWA WA 99349

Place of service	Provider number	Signed?	Date of signature
	358313	YES	11/16/23