STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

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

361

BEACON HILL INC
PO BOX 784
EPHRATA WA 98823-0784

Account No.
139,994-01
Risk Class
4803 02
Claim No.
BM36593
Worker
EMELIA SIMON

July 23, 2025

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.

JULIA CHRISTIAN
Account Manager
360-902-6114
360-902-6690, Fax

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

Please Review This Information and Keep for Your Records

Workers' Compensation Claim

Worker Information

Language preference: SPANISH

Name	Sex	Social Security number	Home phone	Claim number
EMELIA SIMON	FEMALE	XXX-XX-5460		BM36593

Birth date	Home address	Height	Mailing address (if different from home address)	Family status
06/02/77	21281 RD 24.7 SW MATTAWA WA 99349-7215	5 FT 3 IN Weight 140 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
	07/11/25	6 AM	DAY

Body parts injured or exposed
RIGHT EYE

Description of how injury or exposure occurred
I WAS PICKING CHERRY AND BEDRIS GOT IN MY RIGHT EYE

Doing regular job?
YES

Where did the injury or exposure occur?
JOB SITE

Address where injury or exposure occurred
GRANT COUNTY
QUINCY WA 98848
UNITED STATES

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?
		07/11/25

Incident reported to employer? Name and title of person reported to:	Date reported	Employer-paid health care benefits on day injured?
YES	07/11/25	

Business name of employer	Type of business
BEACON HILL	AGRICULTURE

How long worked at business	Employer phone number	Employer address	Owner, partner, or officer?
14 DAYS		PO BOX 366 QUINCY WA 98848	

Job title and duties
LABOR

Rate of pay	Hours/day	Days/week

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

Signed?	Date of signature
YES	07/11/25

(over)

Health Care Provider Information

Diagnosis
SUBCONJ HEM R EY

ICD Diag. Codes
H11.31

Date first visit for this condition
07/11/25

Subjective complaints supporting diagnosis

Objective findings supporting diagnosis
SUBCONJ HEME OD

Treatment and diagnostic testing recommendations
ATS PRN

Was the diagnosed condition caused by this injury or exposure?

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
CBHA (509) 932-3535
601 GOVERNMENT WAY
MATTAWA WA 99349

Attending health care provider
BIANCA MENDOZA
1515 E COLUMBIA ST
OTHELLO WA 99344

Place of service	Provider number	Signed?	Date of signature
	458919	YES	07/11/25

2350100G-000361-02-00000000

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 EMELIA SIMON	3. Claim number BM36593

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: 17. L&I account ID:	16. Body part(s) injured or exposed - *include side of body*	
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**

STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

PO BOX 44291, OLYMPIA, WASHINGTON 98504-4291

July 24, 2025

7968

BEACON HILL INC
PO BOX 784
EPHRATA WA 98823-0784

CLAIM NUMBER BM36593
INJURY DATE 07/11/2025
DATE OF BIRTH 06/02/1977
CLAIMANT SIMON EMELIA

2350110I-007968-01-00000000

Dear Bianca Mendoza DO:

We have received an incomplete Report of Industrial Injury or Occupational Disease for this claim.

Thank you for assisting this worker in filing this claim. More information is needed before a decision can be made regarding allowance.

Unfortunately, Box 7, causal, on the ROA was left blank. Box 7 is required in order to process any claim.

This claim has been placed in undetermined status, pending clarification regarding the causal relationship of the injury. No benefits can be considered at this time.

Please complete Box 7 on the attached ROA, or answer the following questions:

Are you contending that the right eye subconjunctival hematoma is related to the industrial injury of 07/11/2025 on a more probable than not basis (51% or more on a more probable than not basis)?

_____ YES (Probably, 51% chance or more)

_____ NO (Possibly, 50% chance or less)

If yes, please provide how the mechanism of injury caused the contended conditions and provide objective medical findings to support your opinion.

_____

_____

_____

_____

Please provide your response by 08/06/2025 as your response is needed to make a further determination on the claim validity.

If no causal relationship clarification is received, this claim may be rejected.

Thank you for your immediate attention to this matter.

EMPLOYER COPY

(UF47:08:UF)

STATE OF WASHINGTON

DEPARTMENT OF LABOR AND INDUSTRIES

PO BOX 44291, OLYMPIA, WASHINGTON 98504-4291

July 24, 2025

CLAIM NUMBER BM36593
INJURY DATE 07/11/2025
DATE OF BIRTH 06/02/1977
CLAIMANT SIMON EMELIA

If you have any questions, you can contact me at the number below, or send me a secure message online at LNI.WA.GOV

To assist us in making a decision on the claim, please complete, sign and return the enclosed information form. Your signature is required on it by 08/08/2025 so we can process this claim.

Please call me if you have any questions or concerns regarding this claim.

Thank you.

Sincerely,

Drew Arends
Claim Manager, Unit F
PHONE: (360) 902-5294
FAX: (360) 902-4567

ATTACHMENT

ORIG: MISC - CBHA WAHLIKE CLINIC
CC: WORKER - EMELIA SIMON
EMPLOYER - BEACON HILL INC
PROVIDER - MENDOZA BIANCA OD