DR. MORLEY SLUTSKY
WORK RELATED HEARING LOSS EVALUATIONS
SCHEDULING: (800) 990-7924 FAX: (888) 418-7997

Dear **Patient**:

Here are a few things to check prior to coming to the appointment with Dr. Slutsky:

1. **VERIFY WORKER'S COMPENSATION INSURANCE:**
INSURANCE WILL BE EITHER THROUGH LNI'S STATE FUND or THROUGH THE SELF INSURED EMPLOYERS PROCESS (NEED AN SIF-2 FORMS, BELOW)

☐ **Self-Insured Employers**: It is the **most recent employer** where you worked in noise, **IN WA State** for **At Least 1 Year** that determines if it is State Fund or Self Insured. You can ask this employer, contact L & I (1-800-547-8367) or go to the LNI website for self-insured employers (address below) to determine if your claim will be self-insured.

☐ If you are no longer working for this company, it is the **date that you last worked for this company** that determines if your claim is covered as SELF-INSURED or STATE FUND.
http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

☐ **Self-Insured Employers**: If your employer **is determined to be self-insured**, then you must obtain a Self-Insurance Form-2 (**SIF-2 form**) prior to the appointment with Dr. Slutsky.

☐ This may be obtained from the Self-Insured Employer (their Workers Comp Department or H.R. / Benefits Department) or you may call the Third Party Administrator, TPA for this Employer (look at the above website address) and ask TPA to mail this form to you. Bring the SIF-2 into your appointment.

3. **EMPLOYMENT HISTORY HEARING LOSS FORMS**

☐ **LAST WORKED: 7 OR MORE YEARS PRIOR TO YOUR APPOINTMENT**
WE NEED THE MOST RECENT COMPANY YOU WORKED FOR IN WASHINGTON STATE AT LEAST 1 YEAR IN LOUD NOISE ON THE FORMS.

☐ **LAST WORKED: LESS THAN 7 YEARS PRIOR TO YOUR APPOINTMENT**
Make a Blank photocopy of these forms first so you can copy them as many times as needed
Must complete Employment History going BACK TO 18 YEARS OF AGE.
Must place Start and End Dates (WITH MONTHS and YEARS) of EMPLOYMENT.
Start with most recent employer and work backwards to the first employer.

☐ If you are **unsure of the employment dates,** you can order a free work history from the WA Employment Security Department (see attached forms and instructions). However this only goes back to 1987 and you may still have to take a **guess at the dates of employment**. You can also use social security records, tax records and or Union employment records (to name a few sources).

☐ If you do not have these documents than please **make your best guess**.

2 **OCCUPATIONAL HEARING LOSS QUESTIONNAIRE:**

☐ **Review the Occupational Hearing Loss Questionnaire** (2 pages) to make sure they are complete. You may leave areas blank if you are unsure what to fill in and can discuss this with Dr. Slutsky.

☐ Please make sure to place **all medication names** in **block 10** on this form **or** bring a **list of medications** with you.

4 **PRIOR HEARING TESTS**

☐ **ALL prior hearing tests** must be **accounted for** (with the exception of testing in grade school and military testing).

A. Please obtain copies of the tests and bring to the appointment

B. If you had **employment related hearing tests then contact the employer and or vendor who performed the tests and ask for a copy**.

C. If the establishment no longer exists and there is no one to contact then discuss with Dr. Slutsky.

PRIOR MEDICAL EVALUATIONS FOR HEARING LOSS BY A PHYSICIAN

☐ ALL **prior medical evaluations** for hearing loss with a Medical Doctor (M.D. or D.O.) must be accounted for. If the establishment no longer exists and there is no one to contact for this information then discuss this with Dr. Slutsky.

☐ **POTENTIAL OUTCOMES FOR PRIOR HEARING TESTS AND MEDICAL INFORMATION**

A. The place where you had the hearing test gives you a copy of the evaluation (which you should bring with you to the appointment) or they may fax this test to Dr. Slutsky's office at (888) 699-0003.

B. If it is a work related hearing test then please contact the employer or their vendor (who performed the testing) and ask for a copy.

C, Employers (and their vendors) are required to keep tests for a long time so they may still have copies.

D. If you are told the test and or medical evaluations no longer exit then please document the **name and phone number of the person who said the test is no longer available** and bring this information to the appointment.

E If the establishment where testing / medical evaluations no longer exists and there is no one to contact then discuss with Dr. Slutsky.

5. **NO SIGNFICANT NOISE EXPOSURE AT LEAST 14 HOURS PRIOR TO THE APPOINTMENT**

The Washington State Department of Labor and Industries does not allow individuals to be tested unless they have had **minimal exposure to loud noise for at least 14 hours prior to the visit.**

This means for example no riding motorcycles, shooting guns, or working in loud noise for at least 14 hours before being seen.

6. **CANCELLING / MISSING YOUR APPOINTMENT**

Please notify our Office AT LEAST 24 hours in advance at (800) 990-7924 if you are going to miss an appointment and need to reschedule.

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Employment History – Hearing Loss

	Claim Number
Name	Start Date of First Employment

Breaks in Employment History

Please list any break or interruption in your work history. *We must account for all months since your **first start date.***

From (Month/Year)	To (Month/Year)	Reason for Work Interruption

Employment History

Begin with your current job and list all prior employers. Include military service. Specify month and year for employment dates.

Employer Name	Phone Number		
Employer Address	City	State	Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No

If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent

How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?

☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No

If yes, date(s) of audiogram(s):_____

I certify that the information is true and correct to the best of my knowledge.

Signature _____ Date _____

If additional sheets are needed, copy this page. ***Begin with current job and list all prior employers including military service.***

	Claim Number
Name	Start Date of First Employment

Employer Name		Phone Number	
Employer Address		City	State Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No
If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent
How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?
☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No
If yes, date(s) of audiogram(s):_____

Employer Name		Phone Number	
Employer Address		City	State Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No
If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent
How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?
☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No
If yes, date(s) of audiogram(s):_____

I certify that the information is true and correct to the best of my knowledge.

Signature _____ Date _____

Mail completed forms to:
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Occupational Hearing Loss Questionnaire

Name	Claim Number	Injury Date

1. When did you first notice your hearing loss?

2. Was the onset of the hearing loss:
☐ Sudden ☐ Gradual

3. What kind(s) of hearing problems are you having? (Circle letter of all applicable items.)

A. Ringing in ears.
B. Difficulty hearing on the phone.
C. Difficulty hearing spoken communication in one-on-one conversation.
D. Difficulty understanding spoken communication in the presence of surrounding noise.
E. Other – explain:

4. While employed, did your hearing loss interfere with your work?

☐ No
☐ Yes – explain below:

5. Name and address of doctor who told you your hearing loss was occupational?

Name

Address

City State Zip Code

6. How were you notified?

☐ Written (please attach a copy)
☐ Oral
☐ Other – explain below:

7. Have you been examined by any other doctor in the past for hearing loss:

☐ No
☐ Yes – please provide:

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

8. When you were first told by a doctor that your hearing loss was caused by work noise, did he/she also tell you that you should have:

A. Medical Treatment – ☐ No ☐ Yes – explain below:

B. A hearing aid – ☐ No ☐ Yes

C. Did you have an audiogram? ☐ No ☐ Yes

9. Have you ever had hearing aids in the past?

☐ No
☐ Yes – please provide:

Doctor's Name/Clinic Name

Address

City State Zip Code

10. Do you have a health problem for which you must take medication on a regular basis?
☐ No ☐ Yes – explain the health problem and what kind of medication you are taking below:

11. Name and address of doctor prescribing your medications:

Doctor's Name

Address

City State Zip Code

12. Have you had any injury to your ear(s)?

☐ No
☐ Yes – explain below:

13. Have you had any illness that affected your ears or hearing?
☐ No
☐ Yes – indicate when and name of illness:

14 Have you ever had a head injury?
☐ No
☐ Yes – describe the injury below:

15. Have you had any illness involving high fever?
☐ No
☐ Yes – indicate when and name of illness:

16. Have any members of your family suffered hearing loss?
☐ No
☐ Yes – specify relationship (mother, father, uncle, etc):

17. Were you a member of a union or trade when exposed to the noise that you think contributed to your hearing loss?
☐ No
☐ Yes – which union?

18. Do you have any hobbies of non-work activities which involved loud noise such as: (check all that apply)

☐ Loud Music	☐ Snowmobiling	☐ Flying Aircraft
☐ Auto Repair	☐ Motorbiking	☐ Operating Noisy Equipment such as:
☐ Woodworking	☐ Boating	☐ Tractors
☐ Metal Working	☐ Hunting/Target Practicing	☐ Farm Equipment
☐ Wood Cutting	☐ Auto Racing	☐ Lawn Mowers
		☐ Other – please specify:

19. Type of equipment or tools used for hobbies: How Often? How Long (time/duration)?

Please list any hobbies or activities you participate in that involve noise?

20. Current or last rate of pay:
Amount:
$
Rate of pay:
☐ Hour ☐ Day ☐ Week ☐ Month

21. Are you retired?
☐ No
☐ Yes

21A. If you're retired, why did you retire?

21B. If you're retired, what is the last date you worked when you were exposed to noise that you think contributed to your hearing loss? (Give the month and year.)

21C. Did you have a hearing test as any part of a physical exam when you retired?
☐ No
☐ Yes

22. Was your employer contributing to your and/or your family's medical dental, and/or vision insurance on the last day you worked when exposed to noise that you think contributed to your hearing loss?
☐ No
☐ Yes

Date _____ Signature _____

(Select one) Language Preference ☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other _____

MAIL TO SELF-INSURED COMPANY

PROVIDER'S INITIAL REPORT

A Provider's Initial Report (PIR) completed by the provider and the worker, establishes a claim. When the completed PIR is received by the employer, they must assign a claim number and adjudicate the claim.

1.CLAIM NUMBER

1. NAME OF SELF-INSURED EMPLOYER

ADDRESS

CITY | STATE | ZIP

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE

ADDRESS

CITY | STATE | ZIP

EMPLOYER'S TELEPHONE NUMBER | EMPLOYER'S SERVICE REP PHONE

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST | 3. WORKER'S TELEPHONE NO.

4. MAILING ADDRESS | 5. SOCIAL SECURITY NUMBER

6. CITY | STATE | ZIP | 7. DATE OF BIRTH

8. INJURY DATE | 9. TIME | ☐ AM ☐ PM | 10. Have you missed work due to your injury? If so, what dates were you off? From: | To:

11. SEX | 12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS | 12B. NUMBER OF DEPENDENTS

13. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider – **START HERE**

3. This exam date

4. Date patient first seen by you for this injury/condition

a. ICD Dx CODES	b. Diagnosis – specify Right/Left

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, Specify

6. Referred for Diagnostic Studies
☐ No ☐ Yes, Specify

7. Treatment Recommendations

8. Did you refer the patient to an L&I medical network provider for follow-up?
☐ YES ☐ NO Referred to:

Address

Phone

14. MEDICAL RELEASE AUTHORIZATION: PURSUANT TO RCW 51.36.060, I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY RELEVANT MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.

Worker's Signature Date

15. I have read the statement of Responsibility and the Legal Notice on the next page of this form.

Worker's Signature Date

9. a. Has the worker ever been treated for the same or similar condition?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

b. Is there any pre-existing impairment of the injured area?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

c. Are there any conditions that will prevent or retard recovery?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

d. Was the diagnosed condition caused by this work injury or exposure on a more probable than not basis? (check one)
Yes ☐ Probably (51% or more) ☐
No ☐ Possibly (Less than 50%) ☐

10. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?

Lifting Bending

Standing Sitting

Other

d. If not released, how many days off work due to the work injury?

Licensed Healthcare Provider must sign before report is accepted
11. Signature

12. Phone | 13. Date

14. Attending Healthcare Provider Name

15. Address

City | State | ZIP

16. L&I Provider Number or NPI | 17. IRS Account #

DO NOT SEND THIS FORM TO

LABOR & INDUSTRIES

WEB ADDRESS TO CHECK FOR UPDATES OF FORM:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467

NOTE: Beginning Jan. 1, 2013, injured workers will need to get ongoing care from a medical provider who is part of the L&I Medical Provider Network. They may see a non-network provider for the initial visit, but for additional or ongoing care, they will need to transfer to a network provider.

MAIL TO SELF-INSURED COMPANY

1. If the worker brings this form to your office, this box may be pre-printed. If you initiate the form in your office, obtain information from the worker.

2. Have the worker complete this box or obtain information from the worker.

ATTENDING HEALTH CARE PROVIDER INFORMATION

NOTICE: FAILURE TO FILE THIS REPORT WITHIN 5 DAYS FROM THE DATE OF TREATMENT MAY RESULT IN A PENALTY OF $250 IN ACCORDANCE WITH RCW 51.48.060.

3. This exam date.

4. Date you first treated patient for this injury/condition.
a) Insert ICD Dx coding which corresponds to narrative diagnosis in Box 3b.

b) Please list all diagnoses of conditions present which are result of incident or exposure. Also specify which side of body (right/left).

5. Indicate “Yes” or “No”. If “Yes”, list objective findings which support diagnosis. Do not restate diagnosis.

6. Indicate “Yes” or “No”. If “Yes”, specify study and complete findings if known.

7. Indicate treatment recommendations.

8. Specify name, address and phone number of health care provider to whom referred. Treatment beyond the initial visit must be done by providers enrolled in Washington’s workers compensation medical provider network. (This applies to workers of Self-Insured and State Fund employers.) Information to enroll in the network is available at JointheNetwork@Lni.wa.gov. If you choose not to enroll and your patient needs additional treatment, refer him or her to a network provider. The provider directory is available at www.Lni.wa.gov.

9. Indicate “Yes” or “No” and provide the additional information requested.

10. Indicate “Yes” or “No” and provide the additional information requested.

11. Signature of health care provider providing treatment and completing form.

12. Health care provider’s phone number.

13. Date health care provider signs report

14. Print or type your name as it appears on your Department of Labor and Industries payee account.

15. Indicate your full mailing address.

16. Indicate your Department of Labor and Industries issued provider number or NPI.

17. Provide your Internal Revenue Service reporting account number.

PATIENT INFORMATION

1. Leave blank.

2. Name of injured worker.

3. Worker’s phone number.

4. Worker’s mailing address or street address.

5. Worker’s social security number.

6. City, state and ZIP code of worker’s address.

7. Date worker was born.

8. Date accident occurred.

9. Time accident occurred.

10. Dates the worker missed work due to this injury.

11. Indicate -- M = Male F = Female

12A. Marital/Registered Domestic Partnership Status, e.g., M = Married, S = Single, D = Divorced, DP = Registered Domestic Partnership.

12B. Dependents -Number of dependents under age 18 (does not include spouse/domestic partner).

13. Brief description of accident or exposure by worker.

14. Medical Release Authorization. Worker’s signature authorizes the release of relevant medical information.

15. Statement of Responsibility - I have reported or will report this incident or exposure to my employer. If my claim is denied, I understand that I will be responsible for the care provided to me.

16. LEGAL NOTICE --RCW 51.48.020 (2) PROVIDES: ANY PERSON CLAIMING BENEFITS UNDER THIS TITLE WHO KNOWINGLY GIVES FALSE INFORMATION REQUIRED IN ANY CLAIM OR APPLICATION UNDER THIS TITLE SHALL BE GUILTY OF A FELONY, OR A GROSS MISDEMEANOR.

Dr. Morley Slutsky
Work Related Hearing Loss Evaluations

Scheduling: (800) 990 - 7924 Fax: (888) 418- 7997

Mailing Address
4580 Klahanie Dr. S.E., #125 Issaquah WA 98029

FREE WORK HISTORY: -WASHINGTON STATE ESD (EMPLOYMENT SECURITY DEPARTMENT) Public Records Request http://www.esd.wa.gov/newsandinformation/media/public-records-request.php

There are 4 ways to request a Washington State employment history:

Mail, Email, Phone, Fax

MAIL:
Employment Security Department
Records Disclosure Unit
Public Records Officer: Robert L. Page
P.O. Box 9046
Olympia, WA 98507-9046

EMAIL: recordsdisclosure@esd.wa.gov

PHONE: 360-725-9440
Records Disclosure unit is open 9 a.m. to 5 p.m., Monday through Friday, except on state holidays.

FAX: 866-610-9225

Be sure to include your Social Security Number with any request.

You can request that records be either mailed or faxed to you.

If you request your records to be faxed, make sure to **include your fax number**.

It may take several weeks to receive this information.

Employment Security Department
WASHINGTON STATE

SELF-REQUEST FOR RECORDS

A response to your request will be sent within 10 TO 15 BUSINESS DAYS.

1. PROVIDE THE FOLLOWING INFORMATION:

Name (please include any alias or maiden name):

Social Security Number:

2. CHECK ONE OR MORE BOXES TO INDICATE THE RECORDS BEING REQUESTED:

☐ I am requesting a copy of my Employment History from

(start date) through (end date)

☐ I am requesting a copy of my Unemployment Payment History from

(start date) through (end date)

☐ If you are seeking records other than the above (identify here):

3. AUTHORIZATION AND SIGNATURE:

a) Mail or Fax records to:

Name:

Contact Phone #:

Address Line:

City State Zip Code:

Return Fax #:

b) Send Request to:

Employment Security Department

Attn: Records Disclosure Unit

P.O. Box 9046

Olympia WA 98507-9046

Fax # (866)610-9225

Phone # (360) 725-9440

c) I authorize the requested information/records be released and sent to the entity identified in Section 3a.

d) By signing below I declare under the penalty of perjury under the laws of the State of Washington that I am the individual whose records are being requested.

Signature(Required) Date

Rev. 9/13

FROM OFFICE OF DR. M. SLUTSKY

Standard Form 180 (Rev. 10/10) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy**. When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☒ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission **must** be provided:

☒ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☒ Other, explain: **Records to help with adjudication of WA State Dept of L&I claim for hearing loss due to noise exposure**

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran **(Must provide proof of death)**.

Show relationship: _____

(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☒ Other (specify) WA State Dept. of Labor and Industries

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Department of Labor and Industries

Name P.O. Box 44291

Street Apt.

Olympia WA 98504-4291

City State Zip Code

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request

(800) 547 - 8367

Daytime phone

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

Dr. Morley Slutsky

324 West Bay Dr NW, Suite 105 Olympia, WA 98502
Scheduling/Messages: (800) 990-7924 Fax: (888) 418-7997

I-5 HEADING SOUTH (FROM SEATTLE)

TAKE EXIT **105** FROM **I-5 S**

KEEP RIGHT, TAKE EXIT **105 B** (TOWARDS **PORT OF OLYMPIA**)

PROCEED 1.8 MILES, THE ROAD SWERVES TO THE RIGHT AND MERGES ONTO **PLUM ST SE**

PROCEED ON PLUM STEET SE FOR **0.5 MILES IN THE LEFT LANE**

TAKE **LEFT AT EITHER 5TH AVE** (AT 5TH AVE GYM) **OR STATE AVE** (AT SHELL GAS STATION)

AFTER LEFT AT 5TH AVE (5TH AVE GYM)

PROCEED STRAIGHT FOR 0.8 MILES.

AT TRAFFIC CIRCLE, STAY RIGHT, TAKE EXIT ONTO **OLYMPIC WAY NW**

PROCEED 0.1 MILES TO ANOTHER TRAFFIC CIRCLE, STAY RIGHT ONTO **WEST BAY DRIVE NW**

AFTER LEFT AT STATE AVE (SHELL GAS STATION)

PROCEED ABOUT 0.8 MILE (IN RIGHT LANE).

THIS ROAD EVENTUALLY CURVES TO THE LEFT AND THEN TO THE RIGHT AND WILL MERGE INTO **4TH AVE WEST.** STAY IN RIGHT HAND**.**

PROCEED ABOUT 0.4 MILES ON **4TH AVE**, OVER THE BRIDGE,

KEEP **RIGHT** AT TRAFFIC CIRCLE ONTO **OLYMPIC WAY NW**

PROCEED 0.1 MILES UNTIL NEXT TRAFFIC CIRCLE, KEEP RIGHT ONTO **WEST BAY DRIVE NW**

ONCE ON WEST BAY DR. NW

PROCEED 0.2 MILES ON **WEST BAY DR. NW**

LOOK FOR SIGN TO BUILDING # **304 WEST BAY DR. NW**. ON RIGHT SIDE

ALMOST IMMEDIATLEY AFTER THIS BUILDING IS THE **DRIVEWAY FOR 324**

(**DRIVEWAY IS A SHARP TURN**, **SLOWLY PULL IN**)

ONCE IN THE BUILDING TAKE **ELEVATOR** TO **FLOOR # 1, GOING DOWN**

DR. SLUTSKY'S OFFICE (**SUITE 105**) IS FIRST OFFICE ON THE RIGHT, STRAIGHT AHEAD WHEN EXITING THE ELEVATOR

Dr. Morley Slutsky

324 West Bay Dr NW, Suite 105 Olympia, WA 98502
Scheduling/Messages: (800) 990-7924 Fax: (888) 418-7997

I-5 HEADING NORTH (FROM PORTLAND)

TAKE EXIT **105** (**TOWARDS PORT OF OLYMPIA**)

THIS EXIT LOOPS TO THE RIGHT AND MERGES ONTO **HENDERSON BLVD.**

STAY IN LEFT LANE ON **HENDERSON BLVD**. AND PROCEED TO THE END

AT END, TURN LEFT ONTO **PLUM STREET**

PROCEED ON **PLUM STEET SE** FOR **0.5 MILES IN THE LEFT LANE**

TAKE **LEFT AT EITHER 5TH AVE** (AT 5TH AVE GYM) **OR STATE AVE** (AT SHELL GAS STATION)

AFTER LEFT AT 5TH AVE (5TH AVE GYM)

PROCEED STRAIGHT FOR 0.8 MILES.

AT TRAFFIC CIRCLE, STAY RIGHT, TAKE EXIT ONTO **OLYMPIC WAY NW**

PROCEED 0.1 MILES TO ANOTHER TRAFFIC CIRCLE, STAY RIGHT ONTO **WEST BAY DRIVE NW**

AFTER LEFT AT STATE AVE (SHELL GAS STATION)

PROCEED ABOUT 0.8 MILE (IN RIGHT LANE).

THIS ROAD EVENTUALLY CURVES TO THE LEFT AND THEN TO THE RIGHT AND WILL MERGE INTO **4TH AVE WEST.** STAY IN RIGHT HAND**.**

PROCEED ABOUT 0.4 MILES ON **4TH AVE**, OVER THE BRIDGE,

KEEP **RIGHT** AT TRAFFIC CIRCLE ONTO **OLYMPIC WAY NW**

PROCEED 0.1 MILES UNTIL NEXT TRAFFIC CIRCLE, KEEP RIGHT ONTO **WEST BAY DRIVE NW**

ONCE ON WEST BAY DR. NW

PROCEED 0.2 MILES ON **WEST BAY DR. NW**

LOOK FOR SIGN TO BUILDING # **304 WEST BAY DR. NW**. ON RIGHT SIDE

ALMOST IMMEDIATLEY AFTER THIS BUILDING IS THE **DRIVEWAY FOR 324**

(**DRIVEWAY IS A SHARP TURN**, **SLOWLY PULL IN**)

ONCE IN THE BUILDING TAKE **ELEVATOR** TO **FLOOR # 1, GOING DOWN**

DR. SLUTSKY'S OFFICE (**SUITE 105**) IS FIRST OFFICE ON THE RIGHT, STRAIGHT AHEAD WHEN EXITING THE ELEVATOR

Dr. Morley Slutsky

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