Employment Security Department
WASHINGTON STATE
P.O. Box 19020 | Olympia, WA 98507-0020

Power of Attorney Form

Use this form to authorize an employer agent as a designated representative for a business account.

- This authorization allows the Employment Security Department to send and share confidential information about the business listed with the designated representative. This includes information pertaining to the Paid Leave and WA Cares programs.
- By law, the employer is liable for all acts taken or failure to act by the agent on the employer's behalf for any delegated roles assigned to the agent. The law that applies is WAC 192-500-015.

Complete the required information (*) requested below.

Employer information		
First Name* :	**Last Name* :**	
Legal Business Name* :		
Employer Identification Number (EIN)* :	**Unified Business Identifier Number (UBI)* :**	
Mailing Address:		
City :	**State :**	**Zip Code :**
Phone Number* :	**Email Address* :**	
Employer agent information		
First Name* :	**Last Name* :**	
Legal Business Name* :	**Employer Identification Number (EIN)* :**	
Phone Number* :	**Email Address* :**	
Employer Agent ID : *No Agent ID? Register with Leave and Care to receive an employer Agent ID. Go to paidleave.wa.gov to log in or create your account.*		

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Authorizations

Select the role(s) you authorize this employer agent to act on and receive correspondence for :

- ☐ **Wage Reporting** | File quarterly wage reports
- ☐ **Wage Amendments** | Review wage detail history and make wage amendments
- ☐ **Payments** | Make payments and view billing statements
- ☐ **Audits** | Participate in Paid Leave and WA Cares audits
- ☐ **Appeals and Agreements** | Enter into agreements and make oral or written presentation of fact and argument

Employer certification and signature

By signing below, I certify under penalty of perjury that:

- I am the business owner or officer duly authorized to represent this account.
- The information submitted has been examined by me and that the matters and statements set forth are true, correct, and complete.

Authorization Effective Start Date* :

Authorization Effective End Date :

If no end date is provided, authorizations will remain in effect until revoked in writing or through an alternate method authorized by the commissioner.

Employer Signature* :	**Date Signed* :**
Printed Name* :	**Title* :**

Employer agent certification and signature

By signing below, I certify under penalty of perjury that:

- I, and any delegated individual representing my agency, am duly authorized to represent this account.
- The information submitted has been examined by me and that the matters and statements set forth are true, correct, and complete.

Employer Agent Signature* :	**Date Signed* :**
Printed Name* :	**Title* :**