Worker's Claim for Benefits Under the Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Note: Please read the instructions on page 2 before filling out this form. Provide all information requested, and sign and date the bottom of page 1. Do not write in the shaded areas.

OMB Control No: 1240-0002
Expiration Date: 05/31/2028

Employee Information (Please Print Clearly)

1. **Name** (Last, First, Middle Initial): Smith John

2. Social Security Number: 123-45-6789

3. Date of Birth: 05 (Month) 15 (Day) 1970 (Year)

4. Sex: ☐ Male ☒ Female

5. Dependents: ☐ Spouse ☐ Children ☐ Other

6. Address (Street, Apt. #, P.O. Box): 123 Main Street

(City, State, ZIP Code): Anytown NY 12345

7. Telephone Number(s)

a. Home: (555) 123 - 4567

b. Other: ( ) -

8. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

		9. Date of Diagnosis Month	Day	Year
☒	**Cancer** (List Specific Diagnosis Below)			
a.	Lung Cancer	03	10	2020
b.	Mesothelioma	05	15	2021
c.	cancer	01	02	2020
☒	**Beryllium Sensitivity**	04	03	2023
☒	**Chronic Beryllium Disease** (CBD)	07	22	2021
☒	**Chronic Silicosis**	11	15	2019
☒	**Other Work-Related Condition(s) due to exposure to toxic substances or radiation** (List Specific Diagnosis Below)			
a.	Respiratory Complications	01	08	2022
b.	Pulmonary Fibrosis	08	20	2022
c.	Pulmonary thing	08	20	2023

Awards and Other Information

10. Have you filed a lawsuit based on exposure to radiation, beryllium, asbestos or any other toxic substance?	☐ Yes ☒ No
11. Have you filed any state workers' compensation claims in connection with any condition(s) you claim in Item 8?	☐ Yes ☒ No
12. Have you or another person received a settlement or other award in connection with a lawsuit or state workers' compensation claim described in Questions 10 or 11?	☐ Yes ☒ No
13. Have you either pled guilty to or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?	☐ Yes ☒ No
14. Have you applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)? **If yes, provide RECA Claim #:**	☐ Yes ☒ No
15. Have you applied for an award under Section 4 of RECA?	☐ Yes ☒ No

Employee Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once it is submitted must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

Employee Signature: Salvador Alcantara De Jesus Date: 08/01/2025

Resource Center Date Stamp

Print Form | Save Form | Reset Form | Next Page