Employment History for a Claim 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 3 first and provide as much information as possible. Do not write in the shaded areas. Sign and date the bottom of page 2.

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

Employee's Information (print clearly)

1. Employee's Name (Last, First, Middle Initial)	2. Former Name (e.g. Maiden/Legal Change)	3. Social Security Number (If known)

Contact Information for Person Completing this Form (Print clearly)

4. Name (Last, First, Middle Initial)
Bailey Tyler J

6. Address (Street, Apt. #, P.O. Box)
39 Crescent Palm Ct

(City, State, ZIP Code)
Henderson NV 89002

5. Telephone Number(s)
a. Home: ( ) -
b. Work: (808) 772 - 8329
c. Cell/Other: (808) 212 - 3336

Employee's Work History (provide as much information as known - if necessary attach a separate sheet)

In chronological order, ***starting with the most recent period of employment***, provide the complete work history of the employee named above. Provide as much identifying information as known concerning the name of the employer and location (city & state) where the employee performed the work. If you require additional space to explain or clarify a point, attach a signed supplemental statement to this form.

Employer - 1

Start Date: Month / Day / Year
End Date: Month / Day / Year

Facility Name (spell out name)	Specific Location (building/site/mine/mill)	City/State where worked performed

Contractor/sub-contractor or Vendor name(s)

Type of Facility/Employer (check one)
☒ - Department of Energy Facility ☐ - Beryllium Vendor ☐ - Unknown
☐ - Atomic Weapons Facility ☐ - Uranium Miner/Miller/Transporter

Position Title or Mine/Mill Activity

Was a dosimetry badge worn while employed? ☒ YES ☐ NO ☐ Unknown

Work Identification Number

If known, provide the Dosimetry Badge Number:

Description of Work Duties (describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility

Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)

☐ Former Worker Program (FWP) ☐ Radiation Exposure Screening and Education Program (RESEP) ☐ Other Medical Study
☐ Other Medical Surveillance Program ☐ Union Member ☐ Other (specify):

Employer - 2

Start Date: Month | Day | Year

End Date: Month | Day | Year

Facility Name (spell out name)	Specific Location (building/site/mine/mill)	City/State where worked performed
Contractor/sub-contractor or Vendor name(s)	Type of Facility/Employer (check one) ☐ - Department of Energy Facility ☐ - Beryllium Vendor ☐ - Unknown ☐ - Atomic Weapons Facility ☐ - Uranium Miner/Miller/Transporter	
Position Title or Mine/Mill Activity	Was a dosimetry badge worn while employed? ☐ YES ☐ NO ☐ Unknown	
Work Identification Number	If known, provide the Dosimetry Badge Number:	

Description of Work Duties (describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) <u>at this facility</u>

Indicate whether the employee participated in any employer health programs or unions <u>at this facility</u> (check all that apply)

☐ Former Worker Program (FWP) ☐ Radiation Exposure Screening and Education Program (RESEP) ☐ Other Medical Study
☐ Other Medical Surveillance Program ☐ Union Member ☐ Other (specify):

Employer - 3

Start Date: Month | Day | Year

End Date: Month | Day | Year

Facility Name (spell out name)	Specific Location (building/site/mine/mill)	City/State where worked performed
Contractor/sub-contractor or Vendor name(s)	Type of Facility/Employer (check one) ☐ - Department of Energy Facility ☐ - Beryllium Vendor ☐ - Unknown ☐ - Atomic Weapons Facility ☐ - Uranium Miner/Miller/Transporter	
Position Title or Mine/Mill Activity	Was a dosimetry badge worn while employed? ☐ YES ☐ NO ☐ Unknown	
Work Identification Number	If known, provide the Dosimetry Badge Number:	

Description of Work Duties (describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) <u>at this facility</u>

Indicate whether the employee participated in any employer health programs or unions <u>at this facility</u> (check all that apply)

☐ Former Worker Program (FWP) ☐ Radiation Exposure Screening and Education Program (RESEP) ☐ Other Medical Study
☐ Other Medical Surveillance Program ☐ Union Member ☐ Other (specify):

Declaration of the Person Completing this Form

Any person who knowingly makes any false statement, misrepresentation, concealment of fact of 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. I affirm that the information provided on this form is accurate and true. I also authorize the Department of Justice, Social Security Administration, any Former Worker Program, union, medical study or medical surveillance program (or any other person, institution, corporation, or government agency) identified on this form to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

(Signature) (Date)

Resource Center Date Stamp