Impairment/Wage-Loss Benefits 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: 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 area.

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

Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)

2. Case ID Number

3. Address (Street, Apt. #, P.O. Box)

(City, State, ZIP Code)

4. Telephone Number(s)

a. Home: ( ) -

b. Other: ( ) -

5. Options and Selection for Impairment or Wage-Loss Claim(s)

Option A - I have not received a prior impairment and/or wage-loss award because of my accepted condition(s). This claim is for an **initial** award for whole-person impairment and/or wage-loss benefits. Select one or both, as applicable:

☐ Initial claim for whole-person impairment ☐ Initial claims for wage-loss benefit

Date of initial wage-loss from accepted illness _____ / _____ (Month/Year)

Period of wage-loss claimed _____ / _____ (Month/Year TO: _____ / _____ (Month/Year)

Option B – I have previously received an award for impairment and/or wage-loss because of my accepted condition(s). This claim is for **increased** whole-person impairment and/or **additional** wage-loss. For increased impairment, it has been at least 2 years since my last award. For additional wage-loss, it has been one year since my last award. Select one or both, as applicable.

☐ Claim for increased whole-person impairment ☐ Claim for additional wage-loss benefit

6. For Impairment Claims – identify the physician you would like to perform your impairment evaluation: (Select only one)

☐ DEEOIC will arrange for a qualified physician, known as a Contract Medical Consultant (CMC), to perform the impairment evaluation.

☒ A physician of my choosing will perform my whole person impairment.

Physician Name: Dr. Loren Lewis

Address: PO Box 363 Nine Miles Falls, WA 99026

Phone Number: (509) 531-5992

Claimant 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

Date

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