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Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act

COORDINATE REFERENCE GRID
- Grid lines every 50 units
- Red circles mark corners
- Numbers show X,Y coordinates
- Use these coordinates in your generator files

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

Note: 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. You also have the option to complete, digitally sign, and submit the form online at https://eclaimant.dol.gov. If you choose to complete your form online, mailing the form is not necessary.

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) _____ _____ ___

5. Telephone Number(s)
a. Home: (____) ____ - ____
b. Work: (____) ____ - ____
c. Cell/Other: (____) ____ - ____

6. Address (Street, Apt. #, P.O. Box) _____

(City, State, ZIP Code) _____ _____ _____

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 **From Date:** ____ (Month) ____ (Day) ____ (Year) **To Date:** ____ (Month) ____ (Day) ____ (Year)

Facility Name (spell out name)

Specific Location (building/site/mine/mill)

City/State where work 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): _____

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