

## Employee's Claim for Compensation

U.S. Department of Labor  
Employment Standards Administration  
Office of Workers' Compensation Programs

See Instructions On Reverse

OMB No.1215-0160

|   |  |   |  |   |
|---|--|---|--|---|
| 3. Name of person making claim (Type or print)<br>First _____ Middle Initial _____ Last _____   |  |   | 1. OWCP No. _____  |   |
| 5. Claimant's address (number, street, city, state, ZIP code) _____   |  |   | 2. Carrier's No. _____   |   |
|   |  |   | 4. Date of Injury (Mo./day/yr.) _____  |   |
| 7. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female   |  |   | 6. Marital Status _____  |   |
|   |  |   | 10. Did injury cause loss of time beyond day or shift of accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 8. Age or date of birth (Mo./day/yr.) _____   |  | 9. Social Security Number (Required by law) _____   |  | 12. Date and hour pay stopped?<br><input type="checkbox"/> AM <input type="checkbox"/> PM |
| 11. On date of injury give<br>a. Hour began work <input type="checkbox"/> AM <input type="checkbox"/> PM<br>b. Hour of accident <input type="checkbox"/> AM <input type="checkbox"/> PM<br>c. Did you stop work immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 13. Date and hour you returned to work _____  |  |   |
| 14. Occupation (Job title: longshore worker, welder, etc.) _____  |  | 15. Injured while doing regular work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If "No," explain in Item 24)                                |  |   |
| 16. Wages or earnings when injured (include overtime allowances, etc.) \$ _____   |  | 17. Has 3rd party or other claim been made because of this injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                    |  | 20. Name of supervisor at time of accident? _____   |
| 18. Number of years you worked for this employer _____  |  | 19. Number of days usually worked per week _____  |  |   |
| 21. Earliest date supervisor or employer knew of accident _____   |  | 22. Were you employed elsewhere during the week injured?<br><input type="checkbox"/> No <input type="checkbox"/> Yes (If "Yes," state where and when on reverse.) |  |   |
| 23. Exact place where accident occurred (Street address, city, town, name of vessel, pier, terminal, etc.) _____  |  |   |  |   |
| 24. Describe in full how the accident occurred (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. If more space is needed, continue on reverse.) _____ |  |   |  |   |
| 25. Nature of injury (name part of body affected - fractured left leg, bruised right thumb, etc. If there was a loss or loss of use of a part of the body, describe.) _____   |  |   |  |   |
| 26. Have you received medical attention for this injury?<br>(If "Yes," give name and address of doctor, clinic, hospital, etc.)   |  |   | 27. Were you treated by a physician of your choice?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 28. Was such treatment provided by employer?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   | 30. Have you worked during the period of disability?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 29. Are you still disabled on account of this injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 32. Has injury resulted in permanent disability, amputation or serious disfigurement?<br><input type="checkbox"/> Yes (Describe on reverse.) <input type="checkbox"/> No |   |
| 31. Have you received any wages since becoming disabled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," give dates on reverse)  |  |   |  |   |
| 33. Name of employer (Individual or firm name) _____  |  |   | 34. Nature of employer's business _____  |   |
| 35. Address of employer (Number, street, city, state, ZIP code) _____   |  |   | 36. If accident occurred outside the U.S., state whether you are a U.S. Citizen<br><input type="checkbox"/> Yes <input type="checkbox"/> No                              |   |
| 37. I hereby make claim for compensation benefits, monetary and medical, under the _____ Act<br>Signature of claimant<br>or person acting in his/her behalf _____   |  |   | 38. Date of this claim (Mo./day/yr.) _____   |   |

**Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1) provides, as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed \$10,000, by imprisonment not to exceed five years, or by both.**

## Instructions

- Use this form to file a claim under any one of the following laws:

Longshore and Harbor Workers' Compensation Act  
Defense Base Act  
Outer Continental Shelf Lands Act  
Nonappropriated Fund Instrumentalities Act

- Applicant may leave items 1. and 2. blank.

Except as noted below, a claim may be filed within one year after the injury or death (33 U.S.C. 913(a)). If compensation has been paid without an award, a claim may be filed within one year after the last payment. The time for filing a claim does not begin to run until the employee or beneficiary knows, or should have known by the exercise of reasonable diligence, of the relationship between the employment and the injury. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The information will be used to determine an injured worker's entitlement to compensation and medical benefits.

In case of hearing loss, a claim may be filed within one year after receipt by an employee of an audiogram, with the accompanying report thereon, indicating that the employee has suffered a loss of hearing.

In cases involving occupational disease which does not immediately result in death or disability, a claim may be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

To file a claim for compensation benefits, complete and sign two copies of this form and send or give both copies to the Office of Workers' Compensation Programs District Director in the city serving the district where the injury occurred. District Offices of OWCP are located in the following cities.

|           |              |             |                  |
|-----------|--------------|-------------|------------------|
| Baltimore | Honolulu     | New Orleans | Philadelphia     |
| Boston    | Houston      | New York    | San Francisco    |
| Chicago   | Jacksonville | Norfolk     | Seattle          |
|           | Long Beach   |             | Washington, D.C. |

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Use the space below to continue answers. Please number each answer to correspond to the number of the item being continued.

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### PRIVACY ACT NOTICE

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) you are hereby notified that (1) the Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the LHWCA. (3) Information may be given to the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (4) Information may be given to physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (5) Information may be given to the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA, to determine whether benefits are being or have been paid properly, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (7) Disclosure of the claimant's Social Security Number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN and other information maintained by the Office may be used for identification, and for other purposes authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

**Note:** The notice applies to all forms requesting information that you might receive from the Office in connection with the processing and/or adjudication of the claim you filed under the LHWCA and related statutes.

### Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, 200 Constitution Avenue, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**