

# Employee's Claim for Compensation

# U.S. Department of Labor

Employment Standards Administration  
Office of Workers' Compensation Programs



<b>See Instructions On Reverse</b>						OMB No.1215-0160	
3. Name of person making claim (Type or print)						1. OWCP No.	
First		MI.		Last		2. Carrier's No.	
5. Claimant's address (number, street, city, state, ZIP code)						4. Date of Injury	
line1:		city:		state:		zip:	
line2:		country:		6. Marital Status			
				Married		Single	
7. Sex		8. Date of Birth (mm/dd/yyyy)		9. Social Security Number (Required by law)		10. Did injury cause loss of time beyond day or shift of accident?	
Male      Female						Yes      No	
11. On date of injury give	a. Hour began work		b. Hour of accident		c. Did you stop work immediately?	12. Date and hour pay stopped?	
	AM    PM		AM    PM		yes      No	(mm/dd/yyyy)      (hh:mm am/pm)	
13. Date and hour you returned to work (mm/dd/yyyy)      (hh:mm am/pm)		14. Occupation (Job title: longshore worker, welder, etc.)				15. Injured while doing regular work?	
						Yes      No (if "No," explain in Item 24)	
16. Wages or earnings when injured (include overtime allowances, etc.)		a. Weekly		b. Total earnings during year immediately before injury.		17. Has 3rd party or other claim been made because of this Injury?	
						Yes      No	
18. Number of years you worked for this employer		19. Number of days usually worked per week		20. Name of supervisor at time of accident?			
21. Earliest date supervisor or employer knew of accident (mm/dd/yyyy)				22. Were you employed elsewhere during the week injured?			
				No    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? (if "Yes," give name and address of doctor, clinic, hospital, etc.)				Yes      No		27. Were you treated by a physician of your choice?	
						Yes      No	
28. Was such treatment provided by employer?		29. Are you still disabled on account of this injury?		30. Have you worked during the period of disability?			
Yes      No		yes      No		Yes      No			
31. Have you received any wages since becoming disabled? (if "Yes," give dates on reverse)				32. Has injury resulted in permanent disability, amputation or serious disfigurement?			
Yes      No				Yes (Describe on reverse.)      No			
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	
						Yes      No	
37. I hereby make claim for compensation benefits, monetary and medical, under the						38. Date of this claim	
Act						(mm/dd/yyyy)	
Signature of claimant or person acting in his/her behalf							

**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.

All information may be sent to the employer, which employee's name appears on the date of injury or death, the insurance carrier, other entities, and others involved in the claim, or other persons or organizations which are authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim. Information may be given to Federal, State, or local agencies for law enforcement purposes to obtain information which may be useful in the investigation of criminal offenses. Information may also be disclosed to other Federal, State, or local agencies for purposes of identifying and locating persons who are required to register as sex offenders. Information may be used for other purposes authorized by law. (3) Failure to disclose all requested information may affect 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

Following instructions, searching. We estimate that it will take an average of 15 minutes to complete this collection of information, including time for review.