# Employee's Claim for Compensation

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

**See Instructions On Reverse** Print Reset

OMB No.1215-0160

3. Name of person making claim (Type or print)
First MI. Last

1. OWCP No.

2. Carrier's No.

5. Claimant's address (number, street, city, state, ZIP code)
line1:
line2:
city:
state: zip:
country:

4. Date of Injury

6. Marital Status ☐ Married ☐ Single

7. Sex ☐ Male ☐ Female

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? ☐ Yes ☐ No

11. On date of injury give

a. Hour began work ☐ AM ☐ PM

b. Hour of accident ☐ AM ☐ PM

c. Did you stop work immediately? ☐ yes ☐ No

12. Date and hour pay stopped? (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? ☐ Yes ☐ No
(if *Yes," give name and address of doctor, clinic, hospital, etc.)

27. Were you treated by a physician of your choice? ☐ Yes ☐ No

28. Was such treatment provided by employer? ☐ Yes ☐ No

29. Are you still disabled on account of this injury? ☐ yes ☐ No

30. Have you worked during the period of disability? ☐ Yes ☐ No

31. Have you received any wages since becoming disabled? ☐ Yes ☐ No (if "Yes," give dates on reverse)

32. Has injury resulted in permanent disability, amputation or serious disfigurement? ☐ 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** **Act**

**Signature of claimant or person acting in his/her behalf**

38. **Date of this claim** (mm/dd/yyyy)

**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.**

Go to Form

# 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. |

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

**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**

**Public Burden Statement:**

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