

File Number:  
CA-1027-O-P

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION  
OFFICE OF WORKERS' COMP PROGRAMS  
PO BOX 8300 DISTRICT 52  
LONDON, KY 40742-8300  
Phone: (202) 693-0045

February 6, 2021

Date of Injury: 05/08/2005  
Employee: xxxxxxxxxxxx

Dear Mr.:

STEPHEN xxxxxx has submitted a claim in connection with his former Government employment. We understand that STEPHEN xxxxx is now, or has been, employed by your establishment. In order to verify entitlement to compensation, we need the information indicated below. This request for information is authorized by law (5 U.S.C. 8101 et seq.). While you are not required to respond, your cooperation is needed to enable the Office of Workers' Compensation Programs to determine accuracy and propriety of payments under the law. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108. Please return this letter to the office of Workers' Compensation Programs at the above address.

1. Job title and brief description of duties performed.
2. Number of hours worked per week.
3. Inclusive dates of employment.
4. Weekly rate of pay, exclusive of overtime. Include the value of any board lodging, or other advantages received in addition to or in lieu of wages. Show all changes in rate of pay and the approximate date of each change.
5. If STEPHEN xxxxxx has left your employ, explain why.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

Thank you for your assistance.

Sincerely,

Michelle Walker

DEPT OF HOMELAND SECURITY  
TRANSPORTATION SECURITY ADMN  
TWEED-NEW HAVEN AIRPORT S WING  
336 ELLA GRASSO TPKE STE 200

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WINDSOR LOCKS, CT 06096

#### NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to vary from 10 to 20 minutes per response with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the US department of Labor, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, DC 20210. DON NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to complete this form unless it displays a currently valid OMB control number.

OMB No.: 1215-0105

OMB Approved Expiration Date: 03/31/07