

Notice of Law Enforcement Officer's  
Injury Or Occupational Disease

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



**Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.**

OMB No. 1215-0116  
Expires: 08-31-2007

**Statement of Injured Officer**

1. Last, First, Middle Name of Injured Officer		2. Date of Injury (month, day, year)	
3. Hour of Injury  am / pm	4. Location Where Injury Occurred (number, street, building, city, state)		
5. Nature of Injury (e.g., fractured left leg)		6. Did Injury Cause Permanent Disability? If Yes, Describe <input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Described Fully Why and How Injury Occurred

I certify that the injury described above was sustained in performance of official duty and occurred in such a manner as to entitle me to benefits under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.	8. Signature	9. Date Signed
	10. Mailing Address Including ZIP Code	

**Statement of Witness**

1. Describe What You Saw, Heard or Know About This Injury	2. Signature
	3. Date Signed

**Medical Report by Physician who First Attended Injured Officer**

1. Date of First Visit (month, day, year)	2. Nature of Injury
3. Dates of Hospitalization	4. Name and Mailing Address of Hospital
5. Type and Frequency of Treatment	

6. In Your Opinion Was Disability A Result of the Injury Described In Item 7. Of the Statement of the Injured Officer?  
 Yes  No If No, State Your Reason for Believing Officer's Disability Resulted from Other Circumstances

7. Type of Further Treatment Recommended

8. Signature	9. Mailing Address Including ZIP Code
10. Date Signed	

The Office of Workers' Compensation Programs requires this claim before compensation can be awarded to an officer for pay loss, permanent disability, or when the Officer is unable to resume his regular work. The officer completes items 1 through 15 and gives it to the officer's employing organization which will certify as to the validity of the information contained in the claim by completing items 17, 18, and 19. If it does not agree that all answers are correct, it should attach a detailed statement giving the reason for its disagreement. If pay loss is involved, this claim should not be completed until 14 calendar days have elapsed since the beginning of the pay loss, or until the officer has returned to work, whichever occurs first.

7. ATTENDING PHYSICIAN'S MEDICAL REPORT. If the CLAIM FOR COMPENSATION is completed, this report is to be completed by the physician supervising medical treatment. It is not necessary if the CLAIM FOR COMPENSATION is not completed.

8. SUBMITTING THIS FORM. This form should be turned over to the employing organization. The organization will have any remaining parts completed. Afterwards, it should review the form for completeness and to see that all signatures appear. If a report of investigation of any type was made on the injury or the incident leading to injury, a copy should be attached. When the form and any statements and attachments are ready for transmission, this instruction page should be removed. Only one copy of this form (the original) need be submitted.

#### Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 522a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) 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 FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of 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 FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (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, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

**Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.**

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

#### Public Burden Statement

Public reporting burden for this collection of information is estimated to average 60 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

All completed forms, documents, and inquiries should be sent to  
Office of Workers' Compensation Programs  
Washington, D.C. 20211

## Employing Organization's Report

1. Name and Mailing Address Including ZIP Code of Employing Organization		2. Name of Injury Officer's Immediate Superior	
4. Last, First, Middle Name of Injury Officer		5. Officer's Birth Date (month, day, year)	6. Social Security Number
7. Date Employing Organization First Received Injury Notice Date: <input type="checkbox"/> Verbal <input type="checkbox"/> Written		3. Name and Telephone Number of Person to Contact	
9. Date and Hour of Injury am/pm	10. Date and Hour Stopped Work am/pm	11. Date and Hour Pay Stopped am/pm/	12. Date and Hour Returned to Work am/pm
13. Will Officer Receive Pay For Any Portion of Absence From Work Because of the Injury?  <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish		A. Types(s) of Leave	B. Amount Paid
14. Rate of Pay on Date of injury  Base                   \$           Per  Subsistence, If Extra   \$           Per  Quarter, If Extra       \$           Per		C. Dates For Which Leave Paid	
16. On Day of Injury Officer's Shift  	a. Began am/ pm	b. Ended am/ pm	15. List and Show Value of Other Pay Increments on Date of Injury  <div style="text-align: right;">\$           Per</div> <div style="text-align: right;">\$           Per</div>
17. Number of Hours Worked Per Day (exclusive of overtime)		18. Circle Days Normally Worked Per Week (exclusive of overtime) SU MO TU WE TH FR SA	
19. Did Officer Work for the Organization a Full 11 Months Immediately Prior to Injury?  <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, Would His Job Have Afforded Employment For 11 Months Except For the Injury?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Was Officer Performing Regular Duties When Injured? If No, Give Full Explanation		<input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Was the Injury Caused By: a. Officer's Willful Misconduct? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Officer's Intoxication? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Officer's Intent to Bring About Injury to Self or Another (other than normally required in performance of duty)? <input type="checkbox"/> Yes <input type="checkbox"/> No Attach Detailed Explanation for Any "Yes" Answers			
23. If Known, Give Name and Address of Suspect(s) or Witness(es) With Whom Officer Was Involved When Injured.			
24. Describe Fully How the Officer's Injury Occurred While Enforcing the Laws of the United States. If possible, give U.S. Code Citation.			
25. Give Comments Regarding Completeness and Validity of the Facts Provided by Officer (attach detailed explanation if there is disagreement).			
26. Signature		27. Title	28. Date Signed

## Claim for Compensation

1. Last, First, Middle Name of Injured Officer	2. Date of Injury (month, day, year)			
3. Name of Employing Organization	4. Period Compensation is Claimed as a Result of Pay Loss: From _____ Through _____			
5. Has Any Pay Been Claimed or Received for the Period Shown in Item 4? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, State Amount and List Dates	6. Was Subsistence or Quarters Furnished During Period Shown in Item 4? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, State Which and Show Value and inclusive Period			
7. Did Officer Work For Any Other Employer During Period Shown in Item 4?  <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish	A. Name and Address of Employer	B. Amount Earned	C. Period Worked:  From _____  Through _____	
8. Has Claim Been Made Against Any Third Party For Damages on Account of This Injury?  <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes, Furnish	A. Name and Address of Party		B. Amount of Recovery Received	
9. Was Officer Ever in the Armed Forces of the United States?  <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish	A. Service Number	B. Branch of Service	C. Period of Service  From _____  Through _____	
10. If Question 9 is Answered "Yess" Has Application Ever Been Made for Compensation or Pension, Including Retirement or Retainer Pay, on Account of Such Service?  <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish	A. Claim Number	B. Name and Address of Office Where Claim is Filed	C. Nature of Disability and Amount of Monthly Payment	
11. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Furnish	A. Type of Annuity (e.g., civil service retirement)		B. Claim Number	
12. Has Application Been Made For Compensation, Annuity, or Other Benefits as a Result of This Injury Under Any Compensation Law, Police Disability Compensation Fund, or Other Such Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Name and Address of Organization With Which Application Was Filed.			13. If Married, Give Date of Officer's Marriage	
14. List Officer's Dependents. If None. So State				
Name	Relation - ship to Officer	Date Of Birth	Living With Officer?	If Not, Show Mailing Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
15. For Dependents Not Living With Officer, Show Amounts That He Pays for Their Support, to Whom Paid, and Payee's Address. State Whether Such Payments Were Ordered by A Court.				

STATEMENT BY EMPLOYING ORGANIZATION: We hereby certify that the officer who executed the foregoing claim for compensation was injured while in performance of duty under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. All statements made in this claim are true to the best of our knowledge and belief.	16. Signature	17. Date Signed
	18. Title	

**ATTENDING PHYSICIAN'S MEDICAL REPORT**

1. I certify that the above-named officer has been under my professional care for the following period for the effects of this injury.

FROM THROUGH

2. History of Injury

3. Findings	4. Diagnosis
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5. Type and Frequency of Treatment	6. Type of Further Treatment Recommended
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7. In Your Opinion, Was Disability A Result of the Injury as Reported in item 2? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, State Your Reason For Believing Disability Resulted From Other Causes	8. Anticipated Permanent Effects
	9. Other Complicating or Concurrent Diseases or Disabilities Not Due to This Injury

10. As A Result of This Injury, Officer Was Confined to (show dates):  Hospital  Bed Rest at Home  Home	11. Dates Officer Totally Disabled For All Work	12. Date Officer May be Able to Resume Light Work
	13. Dates Officer Partially Disabled For Usual Occupation	14. Date Officer May be Able to Resume Regular Work

15. I certify that the answers to the above questions are true to the best of my knowledge and belief. I am licensed to practice medicine and surgery in the state of	16. Signature	17. Date Signed
	18. Mailing Address Including ZIP Code	

**Public Burden Statement**

Public reporting burden for this collection of information is estimated to average 60 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

## INSTRUCTIONS FOR COMPLETING THIS FORM

(Please do not detach)

1. GENERAL. This form is used to report an injury or occupational disease sustained by a non-Federal law enforcement officer under circumstances involving a crime against the United States. Specifically, section 8191 of title 5, United States Code, provides Federal workmen's compensation benefits for a person determined to have been on any given occasion-

(1) a law enforcement officer and to have been engaged on that occasion in the apprehension or attempted apprehension of any person-

(A) for the commission of a crime against the United States, or

(B) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(C) who at that time was sought as a material witness in a criminal proceeding instituted by the United States; or

(2) a law enforcement officer and to have been engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime; or

(3) a law enforcement officer and to have been engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States;

and to have sustained a personal injury (including disease) related to that occasion. Federal law enforcement officers are excluded from section 8191.

If one of the above conditions is met, this form should be filed with the Office of Workers' Compensation Programs if the injured officer-

(1) is disabled and is in a non-pay status for more than 3 calendar days;

(2) has permanent disability;

(3) is unable to resume his regular work;

(4) incurs unpaid medical expenses; or

(5) if there is a likelihood that disability or unpaid medical expenses will subsequently occur.

The form is designed so that the CLAIM FOR COMPENSATION page may be detached if the claim is not needed. However, read paragraph 6 below thoroughly before detaching the claim page.

If additional space is needed for any answer, attach a separate sheet of paper and write, "see separate sheet," in the appropriate box of this form. Please place the name of the injured officer (and, case file number if known) on any separate sheets. This form must be filed with OWCP within 5 years from the date of injury.

2. STATEMENT OF INJURED OFFICER. This statement must be completed in all instances and only by-

(1) the injured officer, preferably

(2) a member of his immediate family;

(3) his guardian, personal representative, or other person legally authorized to act on his behalf; or

(4) any association of law enforcement officers acting on his behalf.

3. STATEMENT OF WITNESS. This statement normally is used if the injury was not reported at the time that it occurred or if some fact is not clear. It is not necessary if a report of investigation is submitted.

4. MEDICAL REPORT BY PHYSICIAN WHO FIRST ATTENDED INJURED OFFICER. This report is not necessary if a more complete medical report on this form or on another form or in narrative is being submitted.

5. EMPLOYING ORGANIZATION'S REPORT. This report must be completed in every instance. Wage information, duty hours, and like information should be obtained from the organization's records. The organization must review the injured officer's statement and the circumstances of the injury, and in item 25 should comment concerning the completeness and validity of the officer's statement. If the organization disagrees with the officer's statement, it should submit a detailed explanation giving the reasons for its disagreement.

6. CLAIM FOR COMPENSATION. This claim must be completed in every instance where the injured officer-

(1) is disabled and is in a non-pay status for more than 3 calendar days;

(2) has permanent disability; or

(3) is unable to resume his regular work.

It need not be submitted where claim is made only for medical expenses, or if there is only a likelihood that disability or medical expense subsequently will occur.