Employment History Affidavit for a Claim Under the Energy Employees Occupational Illness Compensation Program Act

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

Note: This form is used to affirm the employment history for a claim filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Please do not write in the shaded areas.

OMB No. 1215-0197
Exp Date: 08/31/2007

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Employee's Information (Print clearly)

1. Employee's Name (Last, First, Middle Initial)	2. Maiden/Former Name	3. Social Security Number (If known)

Your Information (Print clearly)

4. Your Name (Last, First, Middle Initial)	5. Your Telephone Number(s)
	a. Home: ( ) -
6. Your Address (Street, Apt. #, P.O. Box)	b. Other: ( ) -
(City, State, ZIP Code)	c. Other: ( ) -

7. Your Relationship to the Employee (Check all that apply)

☐ Work Associate ☐ Spouse ☐ Son/Daughter ☐ Step-child ☐ Parent
☐ Grandparent ☐ Friend ☐ Other:

Employee's Work History

In chronological order, ***starting with the most recent period of employment***, describe your knowledge of the employee's work history. Provide as much identifying information as possible concerning the name of the employer and location (city & state) where the employee performed the work.

Employer - 1 (Provide as much information as possible – if necessary attach a separate sheet)

Your knowledge of where the employee worked (spell out names)	Facility Name: City/State: Building(s): Contractor or sub-contractor name(s):
Dates you know the employee worked at this facility	Start Date: Month Day Year End Date: Month Day Year
What type of work did the employee do? (Describe duties in detail)	Occupation: Title: Duties:
Explain how you know the employee's work history	
If you worked with the employee during this period, provide the following:	Your position and/or title: Dates you worked with the employee: From: To:

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Employer - 2 (Provide as much information as possible – if necessary attach a separate sheet)

Your knowledge of where the employee worked (spell out names)	Facility Name: _____ City/State: _____ Building(s): _____ Contractor or sub-contractor name(s): _____
Dates you know the employee worked at this facility	Start Date: ___ ___ ___ (Month Day Year) End Date: ___ ___ ___ (Month Day Year)
What type of work did the employee do? (Describe duties in detail)	Occupation: _____ Title: _____ Duties:
Explain how you know the employee's work history	
If you worked with the employee during this period, provide the following:	Your position and/or title: _____ Dates you worked with the employee: From: _____ To: _____

Employer - 3 (Provide as much information as possible – if necessary attach a separate sheet)

Your knowledge of where the employee worked (spell out names)	Facility Name: _____ City/State: _____ Building(s): _____ Contractor or sub-contractor name(s): _____
Dates you know the employee worked at this facility	Start Date: ___ ___ ___ (Month Day Year) End Date: ___ ___ ___ (Month Day Year)
What type of work did the employee do? (Describe duties in detail)	Occupation: _____ Title: _____ Duties:
Explain how you know the employee's work history	
If you worked with the employee during this period, provide the following:	Your position and/or title: _____ Dates you worked with the employee: From: _____ To: _____

Declaration of the Person Completing this Form

Any person who knowingly makes any false statement, misrepresentation, concealment of fact of any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I affirm that the information provided on this form is accurate and true.

_____ _____

(Signature) (Date)

Resource Center Date Stamp

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Form EE-4

This form is used to affirm the employment history of a living or deceased Energy employee. The EE-4 is an acceptable format for providing an affidavit in support of an otherwise unsupported work history and can be filled out by anyone with knowledge of a covered employee's work history. Use as many EE-4 forms as needed. If you require additional space to provide comments, attach a signed supplemental statement.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 *et seq*.) (EEOICPA) 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 received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the employee at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN), if known, is mandatory. The SSN 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. (7) 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.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **Do not submit the completed claim form to this address.** Completed claims are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs. Persons are not required to respond to the information collections on this form unless it displays a currently valid OMB number.