

# Rehabilitation Maintenance Certificate

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



No monies or benefits can be paid under this program unless this report is completed and filed as requested by law (5 U.S.C. 8111;33 U.S.C. 901 as extended and amended). The information collected will be handled and stored in compliance with the Freedom of Information Act, Privacy Act of 1974 and OMB Cir. No. 180. Disclosure of a Social Security number is voluntary. The failure to disclose such number will not result in the denial of any right, benefit or privilege to which you may be entitled. However, the Social Security number does expedite the efficient processing of your direct reimbursement.

OMB No.1215-0161  
 Expires: 08-31-2009

1. Name of Injured Worker (First, middle initial, last)	2. OWCP No.	3. Social Security Number (optional)
4. Maintenance Payment Per Week.  \$	5. Maintenance Pay Period (Month, day, year) From                      Thru	6. Appropriate Act (Mark X) <input type="checkbox"/> Federal Employees' Compensation Act <input type="checkbox"/> Longshore and Harbor Workers' Compensation Act <input type="checkbox"/> District of Columbia Compensation Act

**PLEASE READ CAREFULLY** - Submit both copies of this two part form to the Rehabilitation Specialist in the District Office. Complete items 7 thru 9, typing, or printing clearly with a ball point pen; then sign your name legibly in item 10. Next have an official at your facility certify your statement by completing items 11 thru 13.

<b>INJURED WORKER</b>	7. Days Absent From Program (Month, day, year)	8. Reason For Absence(s)
	9. Complete Mailing Address (No., st., city, state, ZIP Code)	
	10. <b>INJURED WORKER:</b> I certify that I participated in my rehabilitation program, as prescribed by the Office of Workers' Compensation Programs, and hereby request a maintenance payment for the above period.	
	Signature	Date Signed

<b>FACILITY OFFICIAL</b>	11. Name	12. Title
	13. <b>FACILITY OFFICIAL:</b> I certify that the above statement in item 7 is true.	
Signature		Date Signed

<b>OWCP REHABILITATION SPECIALIST OR REHABILITATION COUNSELOR</b>	14. REMARKS:	
	15. Amount Approved  \$	16. District Office No.
	17. <b>OWCP REHABILITATION SPECIALIST or REHABILITATION COUNSELOR:</b> I recommend the amount approved be paid to the injured worker.	
Signature		Date Signed

**FOR OWCP USE ONLY**

**Public Burden Statement**

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of the IRM Policy, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**