Attending Physician's Supplementary Report

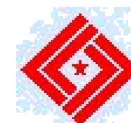
(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor

Employment Standards Asministration

Office of Workers' Compensation Programs

www.dol.gov/esa/owcp/dlhwc/index.ht



INSTRUCTIONS: Use this form to make progress reports and to make a final report when the patient is discharged. Progress reports should be submitted about every thirty days, the original to the District Director (See Item 19 on page 2) and one copy to the insurance carrier or self-insured employer. Please answer all questions fully. If a question is not applicable, enter "NA", The exact point of amputation or others permananent partial impairment must be known to determine compensation the injured is entitled to receive. If preferred, the physician may submit a narrative report covering all information requested on this form. Use "Remarks" on page 2 of form if more space is needed for any answer.	OBM No. 1215-0160 FOR OFFICE USE OWCP No. Carrier's No.

1. Type of report (Mark X one)
   [ ] Progress [ ] Final

2. Date of Injury (mm/dd/yyyy)

3. Name of Injured employee

4. Employee's home address

5. Name of employer

6. Name of insurance carrier

7a. Have you filed a previous report giving history?
[ ] Yes - Skip to item 8 [ ] No - Answer 7b and 7c

7b. State how many injury occurred and give source of information. (If claim is for occupational disease, include occuparional history and date o onse of mated symptoms)

7c. Was employee previously under the care of another physician for this injury?
[ ] No [ ] Yes - Give physician's name and address and reason for transfer

8. Is there any history or evidence of pre-existing injury, disease or physicl impairment?

9a. Present condition (include diagnosis, subjective complaints, objective findings, and any changes of condition since last report.)

9b. If employee was hospitalized since last report, indicate and give name and address of hospital.

10a. Describe treatment provided

10b. Date of first treatment

10c. Date of most recent treatment

10d. Has treatment been terminated?
[ ] No [ ] Yes - Indicate reason

10e. Are you continuing treatment?

10f. If treatment is continuing estimate probable duration

This form is used to request medical information which will be used to determine an injured worker's entitlement to compensation and medical benefits. While you are not required to respond on this form, your cooperation is needed to insure that the injured worker's compensation case is properly processed by the U.S. Department of Labor.

11. Will the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent disfigurement of the head, face, or neck, or some other part of the body which will handicap the employee in securing or maintaining employment?

12. Is employee working?	13. When do you estimate employee can - (mm/dd/yyyy)	
[ ] Yes [ ] No	a. Resume limited work of any kind Date	b. Resume regular work Date

14. If employee is unable to do his/her regular work, but can do lilmited work, specify work limitations due to this injury.

15. In your opinion, was the occurrence described above (or in the previous report which gave this information) the competent producing cause of the injury and disability?

[ ] Yes [ ] No

16. Is rehabilitation treatment or service or evaluation recommended? [ ] Yes - Explain [ ] No - Expalin	17. If rehabilitation treatment or service or evaluation is recommended, has referral been made? [ ] Yes - To Whom [ ] No - Explain
18. Remarks	19. Send the original of your report to: **Office of the District of Columbia** **U.S. Department of Labor** **Office of Workers' Compensation Programs**
20. Name of attending physician (Type or print)	21. Signature of physician

22. Address	23. Telephone No. (Area Code)	24. Date of report

PRIVACY ACT OF 1974 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, (LHWCA) as amended and extended (33 U.S.C. 901 et seq.) 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. (3) Information may be given to the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (4) Information may be given to physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (5) Information may be given to the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with 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 LHWCA to determine whether benefits are being and have been paid properly, and where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (7) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Public Burden Statement

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 33 U.S.C. 907 (b). Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor and a person is not required to respond to, a collection of information unless is displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0160. The time required to complete this informatin collection is estimated to average 30 minutes per response, including the 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 aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C-4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE