Employer's Supplementary Report of Accident or Occupational Illness

Print Reset

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

Notice: This Report must be filed promptly with the District Director in every case in which (1) Form LS-202 does not show date injured employee returned to work, and (2) each time injured employee has returned to work and later becomes disabled for work (33 U.S.C.930(b). If the employee was disabled for work more than 3 days, compensation payments should be reported on Forms LS-206 and LS-208. Medical reports must be sent to the District Director promptly following first treatment and thereafter while treatment continues. Please type or print all information. (if additional space is needed, use back of form.) The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0031

For Office Use

1. OWCP No.

2. Carrier's No.

3. Name of injured employee (First, middle initial, last)
First Name M.I. Last Name

4. Date of accident (Month, day, year)

5. Address of injured employee (Number and Street, City, State, ZIP code)
line 1: country
line 2:
city: st: zip:

6. Name and address of your insurance carrier
city:
st: zip:

7. Initial Period of Disability (Use Inclusive Dates for a and b)

a. From (Month, day, year)	b. To (Month, day, year)	c. Date returned to work (Month, day, year)

8. If this report covers a period of disability after the date shown in item 7c. state each subsequent period of disability. Use inclusive dates for a. and b.

a. From (Month, day, year)	b. To (Month, day, year)	c. Date returned to work (Month, day, year)

9. Did employee receive medical attention?

a. ☐ Yes - Give dates, names and addresses of doctors and hospitals providing treatment.

b. ☐ No - Explain

10. Was employee treated by his or her choice of physician?
☐ Yes ☐ No

11. Was form LS-1 given to employee when injury was reported to you?
☐ Yes ☐ No

12. Name of employer (Firm Name)

13. Employer's address (Number and Street, City, State, ZIP code)
city:
st: zip:
country:

14. Signature of person authorized to sign for employer

15. Name and official title of person signing
name:
title:

16. Date of report (Month, day, year)
07/25/2007

Public Burden Statement

We estimate that it will take an average of 15 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 collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**