Notice of Employee's Injury or Death

Longshore and Harbor Workers' Compensation Act,
As Extended (see instructions on reverse)

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Prgorams
www.dol.gov.esa/owcp/dlhwc/index.htm

This form should be furnished by the employer to any employee covered by the Longshore and Harbor Workers' Compensation Act or a related law who reports an occupational injury or illness to his/her employer. This form is used to provide written notice of an injury or death. The information will be used to determine entitlement to benefits.

OMB No. 1215-0160

1. Employee's Name (Last, First, Middle)		2. Home Mailing Address (Number, Street, City, State, Zip Code)	
3. Date of Birth (Month, Day, Year)	4. Sex [ ] Male [ ] Female	5. Social Security Number (Required by Law)	6. Home Telephone (Area code + Number)
7. Name and Address of Employer (Number, Street, City, State, Zip Code)			8. Employee's Job Title
9. Date of Injury (Month, Day, Year)	10. Hour of Injury	11. Place where Injury Occurred	
12. Name of Supervisor at Time of Injury		13. Did Employee Stop Work Due to Injury? [ ] Yes [ ] No	14. If yes, Date Stopped

15. Cause of Injury (Explain in what way the injury or occupational illness was caused by employment)

16. Effects of Injury (Indicate part of body affected or if death occurred)

NOTE: **If reporting injury, employee signs Item 17; if reporting death, claimant or representative signs Item 18**

17. I am requesting the employer named in item 7 to provide me appropriate compensation and medical care for my injury, and I hereby make claim for all benefits to which I may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

_____ _____ _____
Signature of Employee Date Telephone No.

18. Request is hereby made to the employer named in Item 7 to provide appropriate death benefits to the survivors of the employee named in Item 1, and a claim is hereby made for those death benefits to which these survivors may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

_____ _____ _____
Signature of Employee Date Telephone No.

19. This notice is being personally delivered, or mailed, to the employer named in Item 7 (or his/her representative) and a copy is being sent to the District Director of the Office of Workers' Compensation Programs by the party named in either Item 17 or 18 on this date.

_____
Date

IMPORTANT NOTICE

Section 31(a)(1) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

INSTRUCTIONS TO EMPLOYEE

IT IS IMPORTANT THAT WRITTEN NOTICE OF EMPLOYMENT-CAUSED INJURY OR ILLNESS BE GIVEN PROMPTLY TO THE EMPLOYER AND THE DISTRICT DIRECTOR IN THE LOCAL OFFICE OF THE OFFICE OF WORKERS' COMPENSATION PROGRAMS, U.S. DEPARTMENT OF LABOR.

Written notice needs to be given so that the District Director may see that an employee in case of injury, or his or her survivors in case of death, receive all the benefits to which they may be entitled. No benefit need be paid under the appropriate law unless a notice of injury or death is filed. [33 U.S.C. 912 (a)]

WHO FILES

Injured employees or survivors of employees whose deaths were due to employment covered by the Longshore and Harbor Workers' Compensation Act, or its extensions.

Those Acts which extend the provisions of the Longshore and Harbor Workers' Compensation Act are:

•Defense Base Act •Nonappropriated Fund Instrumentalities Act •Outer Continental Shelf Lands Act

WHEN TO FILE

As soon as possible or within 30 days after the date of injury or death, or

Within 30 days after the employee or survivor first became aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of a relationship between the injury or death and the employment, or

In the case of an occupational disease which does not immediately result in a disability or death, within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability, or

In the case of hearing loss, within 30 days after receipt by an employee of an audiogram, with the accompanying report thereon, indicating that the employee has suffered a loss of hearing.

WHY FILE

The employer needs to have notice so that it or its insurance carrier may see that medical care is given promptly and compensation payments for loss of income may be provided without delay.

WHERE TO FILE

Give original copy to employer and send one copy to the District Director at the following address:

District Director
U.S. Department of Labor
Office of Workers' Compensation Programs (ESA)
Division of Longshore and Harbor Workers' Compensation

FAILURE TO GIVE WRITTEN NOTICE MAY RESULT IN SOME LOSS OF BENEFITS.

Privacy Act 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, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) 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 or have been paid properly, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. 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, and for other purposes authorized 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.

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Public Burden Statement

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the PaperworkRedution Act of 1995, as amended. The authority for requesting the following information is 20 CFR 702.211. 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 15 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 the 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.