Employee's Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
www.dol.gov.esa/owcp/dlhwc/index.htm

See Instructions On Reverse | OBM No. 1215-0160

3. Name of person making claim (Type or print)
First MI. Last

1. OWCP No.
2. Carrier's No.
4. Date of Injury
6. Marital Status [ ] Married [ ] Single

5. Claimant's address (Number, Street, City, State, ZIP Code)
line 1:
line 2:

7. Sex [ ] Male [ ] Female
8. Date of Birth
9. Social Security Number (Required by Law)
10. Did injury cause loss of time beyond day or shift of accident? [ ] Yes [ ] No

11. On date of injury give:
a. Hour began work [ ] AM [ ] PM
b. Hour of accident [ ] AM [ ] PM
c. Did you stop work immediately? [ ] Yes [ ] No
12. Date and hour pay stopped? (mm/dd/yy) hh:mm am/pm)

13. Date and hour you returned to work (mm/dd/yy) (hh:mm am/pm)
14. Occupation (Job title: longshore worker, welder, etc.)
15. Injured while doing regular work? [ ] Yes [ ] No (If "No, " explain in Item 24)

16. Wages or earnings when injured (include overtime allowances, etc.)
a. Weekly
b. Total earnings during year immediately before injury.
17. Has 3rd party or other claim been made because of this injury? [ ] Yes [ ] No

18. Number of years you worked for this employer
19. Number of days usually worked per week
20. Name of supervisor at time of accident

21. Earliest supervisor or employer knew of accident (dd/mm/yy)
22. Were you employed elsewhere during the week injured? (If "Yes," state where and when on reverse.) [ ] Yes [ ] No

23. Exact place where accident occurred (Street address, city, town, name of vessel, pier, terminal, etc.)

24. Describe in full how the accident occurred (relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. If more space is needed, continue on reverse

25. Nature of injury (name part of body affected - i.e., fractured left leg, bruised right thumb, etc. If there was a loss or loss of use of a part of the body, describe.)

26. Have you received medical attention for this injury? [ ] Yes [ ] No
(If "Yes," give name and address of doctor, clinic, hospital, etc.)
27. Were you treated by a physician of your choice? [ ] Yes [ ] No

28. Was such treatment provided by employer? [ ] Yes [ ] No
29. Are you still disabled on account of this injury? [ ] Yes [ ] No
30. Have you worked during the period of disability? [ ] Yes [ ] No

31. Have you received any wages since becoming disabled? (If "Yes, " give dates on reverse) [ ] Yes [ ] No
32. Has injury resulted in permanent disability, amputation or serious disfigurement? [ ] Yes (Describe on reverse) [ ] No

33. Name of employer (Individual or Firm Name)
34. Nature of employer's business

35. Address of employer (Number, Street, City, ZIP Code)
36. Citizenship
37. I hereby make claim for compensation benefits, monetary and medical, under the LHWCA Act

38. Date of this claim (mm/dd/yy)
39.Telephone No.
Signature of claimant or person acting in his/her behalf

Section 31 (a)(1) of the Longshore 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.

Form LS-203
Rev. April 2009

Instructions

Use this form to file a claim under any one of the following laws:

- Longshore and Harbor Workers' Compensation Act
- Defense Base Act
- Outer Continental Shelf Lands Act
- Nonappropriated Fund Instrumentalities Act

Applicant may leave items 1 and 2 blank

Except as noted below, a claim must be filed within one year after the injury or death (33 U.S.C. 913 (a)). If compensation has been paid without an award, a claim may be filed within one year after the last payment. The time for filing a claim does not begin to run until the employee or beneficiary know, or should have known by the exercise of reasonable diligence, of the relationship between the employment and the injury. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The information will be used to determine an injured worker's entitlement to compensation and medical benefits.

In case of hearing loss, a claim may be filed within one year after receipt by an employee of an audiogram, with the accompanying report thereon, indicating that the employee has suffered a loss of hearing.

In cases involving occupational disease which does not immediately result in death or disability, a claim may be filed within two years 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.

To file a claim for compensation benefits, complete and sign two copies of this form and send or give both copies to the Office of Workers' Compensation Programs District Director, DLHWC, in the city serving the district where the injury occurred. District Offices of OWCP, DLHWC are located in the following cities.

Baltimore	Honolulu	New Orleans	Boston
Houston	New York	San Francisco	Jacksonville
Norfolk	Seattle	Long Beach	

Use the space below to continue answers. Please number each answer to correspond to the number of the item being continued.

Privacy Act Notice

In accordance with the Privacy Act of 1974, as amended, (5 U.S.C. 522a), 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.) LHWCA is administered by the Office of Workers Compensation Programs of the U.S. Department of Labor which receives and maintains information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for the amount of benefits 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 the 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 20 CFR 702.221. 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 it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0160. The time required to complete this information 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.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.