



U.S. DEPARTMENT OF LABOR

OMB No: 1215-0105
Expiration Date: XX,XXXX

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT
LONDON, KY 40742-8300
Phone:

Date:

Date of Injury:

Employee Name:

Employer's Name/Address

Dear _____:

_____ (name of claimant) has submitted a claim in connection with his former Government employment. We understand that _____ (name of claimant) is now, or has been, employed by your establishment. In order to verify entitlement to compensation, we need the information indicated below. This request for information is authorized by law (5 U.S.C. 8106). While you are not required to respond to the Office of Workers' Compensation Programs (OWCP), your cooperation is needed to enable the OWCP to determine accuracy and propriety of payments under the law. Please return this letter to the Office of Workers' Compensation Programs at the above address.

1. Job title and brief description of duties performed.
2. Number of hours worked per week.
3. Inclusive dates of employment.
4. Weekly rate of pay, exclusive of overtime. Include the value of any board, lodging, or any other advantages received in addition to or in lieu of wages. Show all changes in rate of pay and the approximate date of each change.

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5. If _____ (name of claimant) has left your employ, explain why.

Signature: _____

Date: _____ Title: _____

Sincerely,

Typed Name/ Signature of
Claims Examiner

cc: Employing Agency

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PRIVACY ACT STATEMENT

The following statement is made in accordance with the Privacy Act of 1974 (5 U.S.C. 522a). The authority for requesting the information is the Federal Employees' Compensation Act (FECA) (5 U. S. C. 8106). Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C.552a). This form is used to request from private employer information about a current federal or former federal employee regarding employment and earnings to determine the nature and extent of continuing entitlement to compensation. Failure to furnish the requested information may result in a delay in processing a claimant's entitlement to compensation benefits.

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PUBLIC BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of this information is estimated to vary from 10 to 20 minutes per response with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary in accordance with 5 U.S.C . 8106 of the FECA. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U. S. Department of Labor, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.