

**Claim For Reimbursement
Assisted Reemployment**

U.S. Department of Labor
Office of Workers' Compensation Programs



Instructions: Complete items 1 through 15 and send to the Division of Rehabilitation. If the claimant has not signed this form, please provide an explanation in the comments section. No further monies may be paid out under this program unless this report is completed and filed, as required by terms of the Cooperative Agreement entered into by you and OWCP. (P.L. 106.554)

OMB No. 1240-0018
Expires: XX-XX-XXXX

1. Employer's Name: _____ 2. Phone Number: _____

3. Employer's Complete Mailing Address: _____ 4. Employer's Tax I.D. Number: _____

(Employer's Name, Street or Post Office Box Number) _____ 5. Employer's Bill Payment Number: _____

City: _____ State: _____ Zip: _____

6. Claimant's Name: _____ 7. OWCP File Number: _____

Last Name _____ First Name _____ M.I. _____ 8. Claimant's Signature: _____

9. Date Employment Began: _____	10. Dates and Hours Worked: From _____ To _____ Hours _____	11. Pay Rate Per Hour: _____	12. Total Amount Earned: _____	13. Amount of Reimbursement Claimed: _____
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Supervisor: If form is unsigned by claimant, please provide an explanation:

I certify that the information provided on this form is true and correct to the best of my knowledge.

14. Supervisor's Signature: _____ 15. Date: _____

For OWCP Use Only Below This Space:

Percentage Allowed: _____ %

Total Amount This Payment: \$ _____

Authorized by: _____ Date: _____

Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act (FECA), as amended and extended (5 U.S.C. 8101, 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 FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to entitlement to benefits or other relevant matters. (4) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (5) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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 information estimated to be 30 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 is required to obtain a benefit (5 U.S.C. 8110). Send comments regarding the burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0018. Note: please do not send the completed form to this office.