Certification by School Official

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

This report is authorized by law (30 U.S.C. 901 et. seq.) While completion of this form is voluntary, your cooperation is needed in returning this form to determine the claimant's eligibility under the Act.	OMB No. 1240-0031 Expires 05-31-2010

This certification is requested on behalf of the student named below to determine his/her entitlement to black lung benefits on the record of the worker named below. Your cooperation in promptly completing and returning this form will be appreciated. An envelope requiring no postage is enclosed for your use. (Please see the reverse side for the Privacy Act statement before completing this form.)

Name and Address of School: (include branch or campus and division) **ATTN: REGISTRAR**	In Replying, Address: U.S. Department of Labor 200 Constitution Ave. NW Washington, DC 20210	
	Telephone Number:	Date:
Name of Miner on whose earnings claim is based:	Miner's Claim Number	

Student

Student's Name:	Student's Date of Birth (mo, day, yr.)
Student Identification Number used by School (If none, enter "None.")	Student's Social Security Number (If none, enter "None.")

Complete All Items below Giving Information Only for Period Indicated.

Attendance

From (mo., day, yr.) ___________ To (mo., day, yr.): ___________ Present

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1. Is the above student now in "Full Time Attendance" According to the School's Standards and Practice's? (For evening students use the same standards applicable to day student**s.)** ☐ Yes ☐ No

2. Was the above student in "Full Time Attendance" according to the School's Standards and practices during entire period entered above?
   ☐ Yes ☐ No (IF "No," answer 3.)

3. If item 2 is answered **"NO"** please enter the beginning and ending dates (up to the present) of the student's **Full Time-Attendance**. If none, enter "None."(If more space is needed, use space on the reverse)	From (mo., day, yr.)
	To (mo., day, yr.)

4. Check the type of school: ☐ Junior College, College or University ☐ High School
   ☐ Technical, Trade or Vocational ☐ Other (Specify) ________________________________

5. (To be completed by all schools except junior colleges, colleges, or universities) Enter the total clock hours per week the student is (was) scheduled to attend; show any variations in scheduled attendance on the reverse:	Total hours per week

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Black Lung Benefits Act, commits a crime punishable under Federal Law, I certify that according to this institution's records the information given above is true.

School Official

Signature of School Official	Title	Date

Previous edition usable

Form CM-981
Rev. Dec. 1999

Privacy Act Statement

The following information is provided in accordance with the Privacy Act of 1974. (1) Submission of this information is required under the Black Lung Benefits Act. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant or beneficiary, or have complied with the provisions of 20 CFR 410 or 20 CFR Part 725. (4) Furnishing all requested information will facilitate the claims adjudication process, and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. Disclosure of your Social Security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 10 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 is voluntary. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N. W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.