Rehabilitation Maintenance Certificate

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

No monies or benefits can be paid under this program unless this report is completed and filed as requested by law (5 U.S.C. 8111;33 U.S.C. 901 as extended and amended). The information collected will be handled and stored in compliance with the Freedom of Information Act, Privacy Act of 1974 and OMB Cir. No. 180.

OMB No.1240-0012
Expires: XX-XX-XXXX

1. Name of Injured Worker (First, Middle Initial, Last)

2. OWCP No.

3. Maintenance Payment Per Week.
$

4. Maintenance Pay Period (Month, Day, Year)
From Thru

5. Appropriate Act (Mark X)
- ☐ Federal Employees' Compensation Act
- ☐ Longshore and Harbor Workers' Compensation Act
- ☐ District of Columbia Compensation Act

INJURED WORKER

PLEASE READ CAREFULLY - Submit both copies of this two part form to the Rehabilitation Specialist in the District Office. Complete items 6 thru 8, typing, or printing clearly with a ball point pen; then sign your name legibly in item 9. Next have an official at your facility certify your statement by completing items 10 thru 12.

6. Days Absent From Program (Month, Day, Year)

7. Reason For Absence(s)

8. Complete Mailing Address (No., Street, City, State, ZIP Code)

Address Line 1

Address Line 2

City State ZIP

9. **INJURED WORKER:** I certify that I participated in my rehabilitation program, as prescribed by the Office of Workers' Compensation Programs, and hereby request a maintenance payment for the above period.

Signature Date Signed

FACILITY OFFICIAL

10. Name

11. Title

12. **FACILITY OFFICIAL:** I certify that the above statement in item 6 is true.

Signature Date Signed

OWCP REHABILITATION SPECIALIST OR REHABILITATION COUNSELOR

13. REMARKS:

14. Amount Approved

15. District Office No.

16. **OWCP REHABILITATION SPECIALIST or REHABILITATION COUNSELOR:**
I recommend the amount approved be paid to the injured worker.

Signature Date Signed

FOR OWCP USE ONLY

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, OWCP, Room S-3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.
DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.