Employment History Affidavit for a Claim Under the Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Note: Please read the instruction on page 3 before filling out this form. Please do not write in the shaded areas. Sign at the bottom of the second page. This form should not be completed by the person who is claiming benefits under EEOICPA. Use as many copies of Form EE-4 as necessary.

OMB Control No. 1240-0002
Expiration Date: XX/XX/20XX

Employee's Information (print clearly)

1. Employee's Name (Last, First, Middle Initial)	2. Maiden/Former Name	3. Social Security Number (If known)

Your Information (print clearly)

4. Your Name (Last, First, Middle Initial)

5. Your Telephone Number(s)

a. Home: ( ) -

b. Work: ( ) -

c. Cell/Other: ( ) -

6. Your Address (Street, Apt. #, P.O. Box)

(City, State, ZIP Code)

7. Your Relationship to the Employee (Check all that apply)

☐ Work Associate ☐ Spouse ☐ Son/Daughter ☐ Step-child ☐ Parent
☐ Grandparent ☐ Friend ☐ Neighbor ☐

Other: _____

Employee's Work History - Use a New Form for Each Period or Place of Employment

Your knowledge of where and for whom the employee worked

(Provide as much identifying information as possible about the name of the employer and location. Spell out all names.)

Facility Name: _____

Facility Location (City/State): _____

Building(s): _____

Contractor or sub-contractor name(s):

Employee's Occupation and Title

Occupation: Title:

Dates you know the employee worked at this facility

Start Date: ___ ___ ___ (Month Day Year) End Date: ___ ___ ___ (Month Day Year)

If you worked with the employee during this period, provide the following:

Your position and title:

Dates you worked at this facility:

From: ___ ___ ___ (Month Day Year) To: ___ ___ ___ (Month Day Year)

Work History Narrative for This Employment: (Be as specific as possible – if necessary attach a separate sheet)

D Describe in detail the type of work the employee performed at this facility. For instance, describe the work processes or work duties the employee was engaged in at this facility. Explain how you know of the employee's presence at this facility and the type of work the employee performed. Include any information you believe would be useful in confirming the employment history.

Declaration of the Person Completing this Form	Resource Center Date Stamp
Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other er act of fraud in a statement to the U.S. government is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I affirm that the information provided on this form is accurate and true. (Signature) (Date)	

Form EE-4

This form is used to affirm the employment history of a living or deceased employee. The EE-4 is an acceptable format for providing an affidavit in support of an otherwise unverified work history and can be filled out by anyone with knowledge of an employee's work history. Use as many EE-4 forms as needed. If you require additional space to provide comments, attach a signed supplemental statement.

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 Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq*.) (EEOICPA) 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 received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the employee to verify statements made, answer questions concerning the status of the claim and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (6) 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.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary. 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, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-4. **Do not submit the completed form to this address.**