# Notice of Law Enforcement Officer's Injury Or Occupational Disease

Print Reset

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

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

OMB No. 1240-0022
Expires: XX-XX-XXXX

**Statement of Injured Officer**

| 1. Last, First, Middle Name of Injured Officer | 2. Date of Injury (month, day, year) |
|---|---|
| 3. Hour of Injury ☐ AM ☐ PM | 4. Location Where Injury Occurred (number, street, building, city, state) |
| 5. Nature of Injury (e.g., fractured left leg) | 6. Did Injury Cause Permanent Disability? ☐ Yes ☐ No<br>If Yes, Describe |

7. Describe Fully Why and How Injury Occurred

| I certify that the injury described above was sustained in performance of official duty and occurred in such a manner as to entitle me to benefits under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury. | 8. Signature | 9. Date Signed |
|---|---|---|
| | 10. Mailing Address Including ZIP Code | |

**Statement of Witness**

| 1. Describe What You Saw, Heard or Know About This Injury | 2. Signature |
|---|---|
| | 3. Date Signed |

**Medical Report by Physician who First Attended Injured Officer**

| 1. Date of First Visit (month, date, year) | 2. Nature of Injury |
|---|---|
| 3. Date of Hospitalization | 4. Name and Mailing Address of Hospital |

5. Type and Frequency of Treatment

6. In Your Opinion Was Disability A Result of the Injury Described In Item 7. Of the Statement of the Injured Officer?
☐ Yes ☐ No If No, State Your Reason for Believing Officer's Disability Resulted from Other Circumstances

7. Type of Further Treatment Recommended

| 8. Signature | 9. Mailing Address Including ZIP Code |
|---|---|
| 10. Date Signed | |

# Employing Organization's Report

1. Name and Mailing Address Including ZIP Code of Employing Organization

2. Name of Injury Officer's Immediate Superior

3. Name and Telephone Number of Person to Contact

4. Last, First, Middle Name of Injury Officer

5. Officer's Birth Date (month, day, year)

6. Social Security Number

7. Date Employing Organization First Received Injury Notice ☐ Yes ☐ No

8. Name of Person to Whom Notice Was First Given

9. Date and Hour of Injury ☐ AM ☐ PM

10. Date and Hour Stopped Work ☐ AM ☐ PM

11. Date and Hour Pay Stopped ☐ AM ☐ PM

12. Date and Hour Returned to Work ☐ AM ☐ PM

13. Will Officer Receive Pay For Any Portion of Absence From Work Because of the Injury?
☐ Yes If yes, furnish →
☐ No

A. Types(s) of Leave

B. Amount Paid

C. Dates For Which Leave Paid

14. Rate of Pay on Date of injury

| | | |
|---|---|---|
| Base | $ | Per |
| Subsistence, If Extra | $ | Per |
| Quarter, If Extra | $ | Per |

15. List and Show Value of Other Pay Increments on Date of Injury

| | |
|---|---|
| $ | Per |
| $ | Per |

16. On Day of Injury Officer's Shift →
A. Began ☐ AM ☐ PM
B. Ended ☐ AM ☐ PM

17. Number of Hours Worked Per Day (exclusive of overtime)

18. Circle Days Normally Worked Per Week (exclusive of overtime)

| SU | MO | TU | WE | TH | FR | SA |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

19. Did Officer Work for the Organization a Full 11 Months Immediately Prior to Injury? ☐ Yes ☐ No

20. If No, Would His Job Have Afforded Employment For 11 Months Except For the Injury? ☐ Yes ☐ No

21. Was Officer Performing Regular Duties When Injured? ☐ Yes ☐ No
If No, Give Full Explanation

22. Was the Injury Caused By:
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No

23. If Known, Give Name and Address of Suspect(s) or Witness(es) With Whom Officer Was Involved When Injured.

24. Describe Fully How the Officer's Injury Occurred While Enforcing the Laws of the United States. If possible, give U.S. Code Citation.

25. Give Comments Regarding Completeness and Validity of the Facts Provided by Officer (attach detailed explanation if there is disagreement).

| 26. Signature | 27. Title | 28. Date Signed |
|---|---|---|
| | | |

# Claim for Compensation

1. Last, First, Middle Name of Injured Officer

2. Date of Injury (month, day, year)

3. Name of Employing Organization

4. Period Compensation is Claimed as a Result of Pay Loss:
   From Through

5. Has Any Pay Been Claimed or Received for the Period Shown in Item 4?
   ☐ Yes ☐ No If Yes, State Amount and List Dates

6. Was Subsistence or Quarters Furnished During Period Shown in Item 4?
   ☐ Yes ☐ No If Yes, State Which and Show Value and inclusive Period

7. Did Officer Work For Any Other Employer During Period Shown in Item 4?
   If yes, furnish →
   ☐ Yes ☐ No
   A. Name and Address of Employer
   B. Amount Earned
   C. Period Worked: From Through

8. Has Claim Been Made Against Any Third Party For Damages on Account of This Injury?
   If yes, furnish →
   ☐ Yes ☐ No
   A. Name and Address of Party
   B. Amount of Recovery Received

9. Was Officer Ever in the Armed Forces of the United States?
   If yes, furnish →
   ☐ Yes ☐ No
   A. Service Number
   B. Branch of Service
   C. Period of Service From Through

10. If Question 9 is Answered "Yes" Has Application Ever Been Made for Compensation or Pension, Including Retirement or Retainer Pay, on Account of Such Service?
    If yes, furnish →
    ☐ Yes ☐ No
    A. Claim Number
    B. Name and Address of Office Where Claim is Filed
    C. Nature of Disability and Amount of Monthly Payment

11. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States?
    If yes, furnish →
    ☐ Yes ☐ No
    A. Type of Annuity (e.g., civil service retirement)
    B. Claim Number

12. Has Application Been Made For Compensation, Annuity, or Other Benefits as a Result of This Injury Under Any Compensation Law, Police Disability Compensation Fund, or Other Such Fund?
    ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.

13. If Married, Give Date of Officer's Marriage

14. List Officer's Dependents. If None. So State

| Name | Relationship To Office | Date of Birth | Living with Officer? Yes | No | If Not, Show Mailing Address |
|---|---|---|---|---|---|
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |
| | | | ☐ | ☐ | |

15. For Dependents Not Living With Officer, Show Amounts That He Pays for Their Support, to Whom Paid, and Payee's Address. State Whether Such Payments Were Ordered by A Court.

16. Name of Financial Institution for Depositing Benefits: ☐ Checking ☐ Savings

17. Account Number: 18. Routing or Transit Number:

| STATEMENT BY EMPLOYING ORGANIZATION: We hereby certify that the officer who executed the foregoing claim for compensation was injured while in performance of duty under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. All statements made in this claim are true to the best of our knowledge and belief. | 19. Signature | 20. Date Signed |
|---|---|---|
| | 21. Title | |

# INSTRUCTIONS FOR COMPLETING THIS FORM

(Please do not detach)

1. GENERAL. This form is used to report an injury or occupational disease sustained by a non-Federal law enforcement officer under circumstances involving a crime against the United States. Specifically, section 8191 of title 5, United States Code, provides Federal workmen's compensation benefits for a person determined to have been on any given occasion-

(1) a law enforcement officer and to have been engaged on that occasion in the apprehension or attempted apprehension of any person-

(A) for the commission of a crime against the United States, or

(B) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(C) who at that time was sought as a material witness in a criminal proceeding instituted by the United States: or

(2) a law enforcement officer and to have been engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime; or

(3) a law enforcement officer and to have been engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States;

and to have sustained a personal injury (including disease) related to that occasion. Federal law enforcement officers are excluded from section 8191.

If one of the above conditions is met, this form should be filed with the Office of Workers' Compensation Programs if the injured officer

(1) is disabled and is in a, non-pay status for more than 3 calendar days;

(2) has permanent disability;

(3) is unable to resume his regular work;

(4) incurs unpaid medical expenses; or

(5) if there is a likelihood that disability or unpaid medical expenses will subsequently occur.

The form is designed so that the CLAIM FOR COMPENSATION page may be detached if the claim is not needed. However, read paragraph 6 below thoroughly before detaching the claim page.

If additional space is needed for any answer, attach a separate sheet of paper and write, "see separate sheet," in the appropriate box of this form. Please place the name of the injured officer (and, case file number if known) on any separate sheets. This form must be filed with OWCP within 5 years from the date of injury.

2. STATEMENT OF INJURED OFFICER. This statement must be completed in all instances and only by-

(1) the injured officer, preferably

(2) a member of his immediate family;

(3) his guardian, personal representative, or other person legally authorized to act on his behalf; or

(4) any association of law enforcement officers acting on his behalf.

3. STATEMENT OF WITNESS. This statement normally is used if the injury was not reported at the time that it occurred or if some fact is not clear. It is not necessary if a report of investigation is submitted.

4. MEDICAL REPORT BY PHYSICIAN WHO FIRST ATTENDED INJURED OFFICER. This report is not necessary if a more complete medical report on this form or on another form or in narrative is being submitted.

5. EMPLOYING ORGANIZATION'S REPORT. This report must be completed in every instance. Wage information, duty hours, and like information should be obtained from the organization's records. The organization must review the injured officer's statement and the circumstances of the injury, and in item 25 should comment concerning the completeness and validity of the officer's statement, If the organization disagrees with the officer's statement, it should submit a detailed explanation giving the reasons for its disagreement.

6. CLAIM FOR COMPENSATION. This claim must be completed in every instance where the injured officer-

(1 ) is disabled and is in a non-pay status for more than 3 calendar days;

(2) has permanent disability; or

(3) is unable to resume his regular work.

It need not be submitted where claim is made only for medical expenses, or if there is only a likelihood that disability or medical expense subsequently will occur.

7. DIRECT DEPOSIT INFORMATION. The Department of Treasury requires all Federal payments be made by electronic funds transfer (EFT), also called Direct Deposit. You may submit a completed SF-1199A, Direct Deposit Sign Up, or complete the information in items 16 through 18 of this form. If you do not have a bank account, you may be required to receive your payment through Direct Express Debit MasterCard. To request information on the Direct Express Debit MasterCard, go to www.usdirectexpress.com or call 1-800-333-1795. If directed to enroll in the Program, you may contact for the Department of Treasury at 1-888-224-2950 to address any questions or concerns you may have, as well as apply for a waiver from the process. NOTE: payments to residents of foreign countries are exempt from the Treasury requirement.

The Office of Workers' Compensation Programs requires this claim before compensation can be awarded to an officer for pay loss, permanent disability, or when the Officer is unable to resume his regular work. The officer completes items 1 through 18 and gives it to the officer's employing organization which will certify as to the validity of the information contained in the claim by completing items 19, 20, and 21. If it does not agree that all answers are correct, it should attach a detailed statement giving the reason for its disagreement. If pay loss is involved, this claim should not be completed until 14 calendar days have elapsed since the beginning of the pay loss, or until the officer has returned to work, whichever occurs first.

8. ATTENDING PHYSICIAN'S MEDICAL REPORT. If the CLAIM FOR COMPENSATION is completed, this report is to be completed by the physician supervising medical treatment. It is not necessary if the CLAIM FOR COMPENSATION is not completed.

9. SUBMITTING THIS FORM. This form should be turned over to the employing organization. The organization will have any remaining parts completed. Afterwards, it should review the form for completeness and to see that all signatures appear. If a report of investigation of any type was made on the injury or the incident leading to injury, a copy should be attached. When the form and any statements and attachments are ready for transmission, this instruction page should be removed. Only one copy of this form (the original) need be submitted.

**Privacy Act**

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, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) 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 retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) 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. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Completion of this form is voluntary; however, 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.

**Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.**

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

**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 average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the date needed, and completing and reviewing the collection of information. The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. 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, and reference OMB Control Number 1240-0022. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS.

All completed forms, documents, and inquiries should be sent to
OWCP, Dist Office 9, Cleveland
1240 East Ninth Street, Room 851
Cleveland, Ohio 44199

**Accommodation Statement**

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.