NOTICE TO REVIEWER

Date: July 3, 2014

Request Type: Non-substantive Change

Employing Agency: Office of Workers' Compensation Programs/Division of Longshore and Harbor Workers' Compensation (DLHWC)

Form Number/Name: LS-203/ Employee's Claim for Compensation

OMB/Expiration Date: 1240-0014/ August 31, 2015

Justification:

Currently, on the back of the LS-203 the directions tell the user:

To file a claim for compensation benefits, complete and sign two copies of this form and send or give both copies to the Office of Workers' Compensation Programs District Director in the city serving the district where the injury occurred. District Offices of OWCP are located in the following cities. Baltimore New Orleans Honolulu Boston Houston New York San Francisco Chicago Jacksonville Norfolk Seattle Long Beach Washington, D.C.

Because the Program now has central mailing addresses (and no longer needs 2 copies since our files are imaged), we'd like to change the wording to this:

To file a claim for compensation benefits, complete and sign this form.

If you have already been assigned an OWCP Case Number, please be sure to include your case number and submit it to the OWCP/DLHWC Central Mail Receipt site at the following address:

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

If this is a new claim, and you do not have an OWCP Case Number, please submit it to the OWCP/DLHWC Central Case Create site at the following address:

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
201 Varick Street, Room 740
Post Office Box 249
New York, NY 10014-0249