Employer's Supplementary Report of Accident or Occupational Illness

Print Reset

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

Notice: This Report should be filed promptly with the District Director in every case in which (1) Form LS-202 does not show date injured employee returned to work, and (2) each time injured employee has returned to work and later becomes disabled for work (33 U.S.C.930(b) if the information is not already reported via Form LS-206 or LS-208. If the employee was disabled for work more than 3 days, compensation payments should be reported on Forms LS-206 and LS-208. Medical reports must be sent to the District Director promptly following first treatment and thereafter while treatment continues. Please type or print all information. (if additional space is needed, use back of form.) The information will be used to determine entitlement to benefits.

OMB No. 1240-0003

For Office Use

1. OWCP No.

2. Carrier's No.

3. Name of injured employee (First, middle initial, last)

4. Date of accident (Month, day, year)

5. Address of injured employee (Number and Street, City, State, ZIP code)

6. Name and address of your insurance carrier

7. Initial Period of Disability (Use Inclusive Dates for a and b)

a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

8. If this report covers a period of disability after the date shown in item 7c. state each subsequent period of disability. Use inclusive dates for a. and b.

a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

9. Did employee receive medical attention?

a. ☐ Yes - Give dates, names and addresses of doctors and hospitals providing treatment.

b. ☐ No - Explain

10. Was employee treated by his or her choice of physician?

☐ Yes ☐ No

11. Was form LS-1 given to employee when injury was reported to you?

☐ Yes ☐ No

12. Name of employer (Firm Name)

13. Employer's address (Number and Street, City, State, ZIP code)

14. Signature of person authorized to sign for employer

15. Name, official title and phone number of person signing

16. Date of report (month, day, year)

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 information is estimated to average 15 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. (33 U.S.C. 930(b)). 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, 200 Constitution Avenue, NW, Room C-4319, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.