Rehabilitation Maintenance Certificate

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

Print Reset

IMPORTANT: 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. 130.

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See additional guidance below for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

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

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

2. OWCP No.

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

Address Line 1

Address Line 2

City State ZIP

4. Maintenance Payment Per Week
$

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

6. Appropriate Act (Mark X)
☐ Federal Employees' Compensation Act
☐ Longshore and Harbor Workers' Compensation Act

INJURED WORKER

PLEASE READ CAREFULLY - Submit this form to the Rehabilitation Counselor assigned to your case by OWCP. Complete items 7 thru 9, typing, or printing clearly with a ball point pen; then sign your name legibly in item 10. Next have an official at your facility certify your statement by completing items 11 thru 13.

7. Weekly Training Schedule ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Other

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

9. Reason For Absence(s)

10. **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

11. Name

12. Title

13. **FACILITY OFFICIAL:** I certify that the above statement in item 8 is true.

Signature Date Signed

OWCP REHABILITATION SPECIALIST OR REHABILITATION COUNSELOR

14. REMARKS:

15. Amount Approved

16. District Office No.

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

Signature Date Signed

FOR OWCP USE ONLY

REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES

IF YOU HAVE A DISABILITY, FEDERAL LAW GIVES YOU THE RIGHT TO RECEIVE HELP FROM THE OWCP IN THE FORM OF COMMUNICATION ASSISTANCE, ACCOMMODATION(S) AND/OR MODIFICATION(S) TO AID YOU IN THE OWCP 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 ACCOMMODATE YOUR DISABILITY. PLEASE CONTACT OUR OFFICE OR YOUR OWCP CLAIMS EXAMINER TO ASK ABOUT THIS ASSISTANCE.

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 Federal Employees Compensation Act (FECA) as amended and extended (5 U.S.C. 8101, et seq.) and the Longshore and Harbor Workers' Compensation Act (LHWCA), as amended and extended (33 USC 901 *et seq.*) are 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 LHWCA 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 entitlement to benefits or other relevant matters. (4) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA and LHWCA 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 LHWCA and/or the Debt Collection Act. (5) 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.

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 estimated to be 10 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. The obligation to respond to this collection is required to obtain a benefit (5 U.S.C. 8101 and 33 U.S.C. 901). Send comments regarding the burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0012. Note: please do not send the completed form to this office.