

**Employer's First Report of Injury
or Occupational Illness**
(See instructions on reverse)

U.S. Department of Labor

Office of Workers' Compensation Programs



OMB No. 1240-0003
Expires: XX-XX-XXXX

1. OWCP No.		2. Carrier's No.		3. Date and Time of Accident (mm/dd/yyyy) (hh:mm am/pm)	
4. Name of injured/deceased employee (Type or print - first, M.I., last) First Name M.I. Last Name Telephone			5. Employee's address (No., street, city, state, ZIP, country) Street: City: St: Zip: Ctry:		
6. Injury is reported under the following Act (Mark one) A <input type="checkbox"/> Longshore and Harbor Workers' Compensation Act B <input type="checkbox"/> Nonappropriated Fund Instrumentalities Act C <input type="checkbox"/> Outer Continental Shelf Lands Act D <input type="checkbox"/> Defense Base Act 1. Contracting Agency 2. Prime Contract # 3. Sub-Contract #		7. Indicate where injury occurred (Longshore Act only) (Mark one) A <input type="checkbox"/> Aboard vessel or over navigable waters B <input type="checkbox"/> Pier/Wharf C <input type="checkbox"/> Dry dock D <input type="checkbox"/> Marine terminal E <input type="checkbox"/> Building way F <input type="checkbox"/> Marine railway G <input type="checkbox"/> Other adjoining area		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Non-binary	9. Date of birth (mm/dd/yyyy)
		10. Social security no. (Required by law)	10a. Nationality (DBA only)		11. Did injury cause death? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, skip to 16
		12. Did injury cause loss of time beyond day or shift of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Date and hour employee first lost time because of injury Date (mm/dd/yyyy) Time (hh:mm am/pm)	
14. Did employee stop work immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Date & hour empl returned to work (mm/dd/yyyy) (hh:mm am/pm)		16. Was employee doing usual work when injured/killed? (if no, explain in Item 26) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Did injury/death occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Dept. in which employee normally works(ed)		19. Occupation	
20. Date and hour pay stopped (mm/dd/yyyy) (hh:mm am/pm)		21. Which days usually worked per week? (Mark (X) days) S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		22. Date employer or foreman first knew of accident. (mm/dd/yyyy) (hh:mm am/pm)	
23. Wages or earnings (include overtime, allowances, etc.) a. Hourly b. Daily c. Weekly d. Yearly		24. Exact place where accident occurred including city, state and country if outside U.S. This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.		25. How was knowledge of accident or occupational illness gained?	
26. Describe in full how the accident occurred (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.)					
27. Nature of Injury (Name part of body affected - fractured left leg, bruised right thumb, etc.) If there was amputation of a member of the body, describe.					
28a. Has medical attention been authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No		28b. LS-1 issued? Yes <input type="checkbox"/> No <input type="checkbox"/>		29. Enter date of authorization.	30. Was first treating physician chosen by employee? <input type="checkbox"/> Yes <input type="checkbox"/> No
				31. Has insurance carrier been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of:			Address - Enter number, street, city, state, zip code		
32. Physician					
33. Hospital					
34. Insurance Carrier					
35. Employer					
36. Employer's Business		37. Signature of person authorized to sign for employer		Phone number	
38. Official title and phone number of person signing this report		Name of person signing this report		39. Date of this report (mm/dd/yyyy)	

This report is required by 33 U.S.C. 930(a) and must be filed with the U.S. Department of Labor, Office of Workers' Compensation Programs, Division of Longshore and Harbor Workers' Compensation by electronic submission via OWCP web portal, facsimile or Central Mail Receipt Site. File form within 10 days from the date of injury or death or from the date the employer first has knowledge of an injury or death. Under the law all medical treatment and compensation must be furnished by the employer or its insurance company. Treatment must be by a physician chosen by the employee, unless the physician is on a list of physicians currently not authorized by the Department of Labor to render medical care under the Act. Compensation payments become due and are payable on the 14th day after the employer first has knowledge of the injury or death. Penalties may be charged for failure to comply with provisions of the law. The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. For further information, visit our website at <https://www.dol.gov/owcp/dlhwc/lscntac.htm>

REPORTABLE INJURY – Any accidental injury which causes loss of one or more shifts of work or death allegedly arising out of and in the course of employment, including any occupational disease or infection believed or alleged to have arisen naturally out of such employment, or as a natural or unavoidable result from an accidental injury. If the employer controverts the right to compensation it must also file a notice of controversion with the District Director within 14 days after it has knowledge of the alleged injury or death.

Item 6 – A. Longshore and Harbor Workers' Compensation Act covers employees injured while engaged in maritime employment upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, or building a vessel); - employees injured upon the navigable waters of the United States and other described areas who at the time of injury were engaged in maritime employment and are not otherwise specifically excluded under the Act (33 U.S.C. 902).

B. Nonappropriated Fund Instrumentalities Act covers employees of nonappropriated fund instrumentalities of the Armed forces, e.g., post exchanges, motion picture service, etc.

C. Outer Continental Shelf Lands Act covers employees of private employers engaged in operations conducted on the Outer Continental Shelf for the purpose of exploring for, developing, removing, or transporting by pipeline the natural resources of submerged lands.

D. Defense Base Act covers any employment (1) at military, air, and naval bases acquired by the United States from foreign countries; (2) on lands occupied or used by the United States for military or naval purposes outside the continental limits of the United States; (3) upon any public work in any Territory or possession outside the continental United States under a contract of a contractor with the United States; (4) under a contract entered into with the United States where such contract is to be performed outside the continental United States and at places not within the areas described in (1), (2), and (3) above for the purpose of engaging in public work; (5) under certain contracts approved and financed by the United States under the Mutual Security Act of 1954, as amended; and (6) in the service of American employers providing welfare or similar services for the benefit of the Armed Forces outside the Continental United States.

Item 24 – "Exact place where accident occurred" requires the nearest street address, city and town. In addition -

I If on a vessel,
Give place on vessel where injury happened (Deck, hold, tweendeck, engine room, etc.) Name of vessel

I If either on an adjoining pier, wharf, dry dock, terminal building way, marine railway, or other area customarily used in loading, unloading, repairing, or building a vessel

Name or number of pier, dry dock, marine railway, etc.
Name of the terminal or shipyard
Nearest street address – City and State

I If injury or death is reported under the Defense Base Act, give the name of the country where injury or death occurred.

I If on the Outer Continental Shelf,
Give drilling site and block number
Area name (e.g. West Delta Area)
Federal Lease Number, State Lease Number
Distance from and name of nearest land,
name of State

NOTE: FILING THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE COMPENSATION ACT. Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails to submit this report when required or knowingly or willfully makes a false statement or misrepresentation in this report shall be subject to a civil penalty not to exceed \$11,000 for each such failure, refusal, false statement, or misrepresentation. [33 U.S.C.930(e)] This report shall not be evidence of any fact stated herein in any proceeding in respect to any such injury or death on account of which the report is made. [33 U.S.C. 930(c)]

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 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, N.W., Room S-3229, Washington, D.C. 20210, and reference the OMB Control Number. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**