# Pre-Hearing Statement

Longshore and Harbor Workers' Compensation

Print Reset

# U.S. Department of Labor

Office of Workers' Compensation Programs

**This form will be used by OWCP to refer the claim for a formal hearing. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.**

OMB No. 1240-0036
Expire: 10/31/2020

**Submit form 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, Room 63A, Box 28**
**Jacksonville, FL 32202**

**Or upload directly to the case file using the Secure Electronic Access Portal (SEAPortal)**
**Access the SEAPortal directly at:**
**https://seaportal.dol-esa.gov**

| 1. Employee's name (Last, first, middle) | OWCP No. | Carrier No. |
|---|---|---|
| | | |

| 2. Name, address and phone number of party on whose behalf this form is submitted: | 3. Name, address and phone number of party's representative: |
|---|---|
| Telephone No. United States | Telephone No. United States |

4. Briefly state the facts of the claim:

5. State the issues on which the parties have reached agreement:

6. State the issues you will present for resolution at formal hearing:

7. List the names of witnesses who will testify in person on your behalf at formal hearing. Also list reports that are to be submitted in lieu of live testimony:

8. List all exhibits, other than reports listed in item 7 above, you intend to submit at the formal hearing. (Use separate sheet or sheets if necessary).

| 9. Estimate total hours needed for your witnesses to testify: | 10. If an interpreter is required, state language: | 11. Indicate the city of your preference for formal hearing: |
|---|---|---|
| | | |

**Note: Any other matters pertinent to scheduling should be explained on a separate sheet attached to this form.**

| 12. Type or print name of person completing form. | 13. Signature of person completing form: | 14. Date (Mo., 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 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20 CFR 702.317). 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 S-3229, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.