(STATE AGENCY IDENTIFICATION)

REQUEST FOR INFORMATION REGARDING CLAIMS FILED UNDER THE FEDERAL EMPLOYEES' COMPONSATION ACT

1. Name (Last, First, Middle, If any)		2. Social Security Number	
3. Local Office/Call Center:	4. Date of Request:	5. Effective Date of Claim	6. Separation Date

7. Federal Agency Name, 3 Digit Agency Code, and Address:

SECTION II. FEDERAL AGENCY REPLY

Instructions: Federal agency to complete at least Item I of Section II and return copy to state agency as soon as possible; extensive delay may cause unnecessary postponement of unemployment benefits or result in overpayment of such benefits.

1. Has the above employee filed a claim for Federal employees' compensation? __ Yes ___ No

2. Date claim Filed	3. "X" one only: CLAIM IS/WAS __----APPROVED; ----- REJECTED; ---- PENDING

NOTE: If claim is "pending," please return one copy of this form to the state (address on reverse) completed through above item. Subsequently, when a decision has been made, please furnish – on a second copy of this form – appropriate, complete information and send it to the State agency.

4. If claim was "approved" rate of compensation $	5. "X" one only: rate in item 4 is for -- week; -- 2 weeks -- month	6. Date Compensation Began	7. Ending Date If Known

8. Describe the disability for which compensation was claimed in terms of nature, degree, and expected duration:

9. List compensation paid for the past periods with respect to week-ending dates *(If any)* shown below. *(If none shown, information is not needed by state agency)*

WEEK ENDING	AMOUNT	WEEK ENDING	AMOUNT	WEEK ENDING	AMOUNT

10. REMARKS:

SECTION III CERTIFICATION

I CERTIFY THAT I have examined this report and that the shown information was obtained from the official records of this agency (see address on reverse.)

1. Signature of Official	2. TITLE	3. DATE

4. Name of this Federal Agency (If different from that shown on reverse)	5. ADDRESS OF THIS OFFICE (If different from address shown on reverse)

ETA-933 (Revised 3/2003)

O M B No.: 1205-0179 O M B **Expiration Date:** XX/XX/XXXX **Average Estimated Response Time:** 5 Minutes

O M B Burden Statement: These reporting instructions have been approved under the Paperwork reduction Act of 1995. Persons are not required to respond to this collection of information unless it displays a valid OMB control number. Public reporting burden for this collection of information includes the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Submission is required to retain or obtain benefits under SSA 303(a)(6). Respondents have no expectation of confidentiality. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workforce Security, Room S-4231, 200 Constitution Ave., NW, Washington, DC, 20210.