Employers' Claim For Reimbursement
Assisted Reemployment (AR) Program

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

Instructions: Complete items 1 through 15 and send to the Division of Rehabilitation. If the employee has not signed this form, please provide an explanation in the comments section. No further monies may be paid out under this program unless this report is completed and filed, as required by terms of the Cooperative Agreement entered into by you and OWCP. (P.L. 113-235)

If you have a disability, Federal law gives you the right to receive help from the OWCP, DFEC in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the FECA claims process. For example, we will provide you with the 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.

OMB No. 1240-0018
Expires: XX-XX-XXXX

1. Employer's Name:

2. Phone Number:

3. Employer's Street or Post Office Box Number

4. Employer's Tax I.D. Number:

City: State: Zip:

5. Employer's Assigned Bill Payment/Provider Number:

6. Employee's Name:

Last Name First Name M.I.

7. Employee's OWCP File Number:

8. Employee's Signature:

9. Date of AR Agreement:	10. Work Date Range Claimed and Total Work Hours for Reimbursement: From / To / Total Hours	11. Pay Rate Per Hour:	12. Total Gross Amount Earned:	13. Amount of Reimbursement Claimed:

Supervisor: If form is unsigned by employee, please provide an explanation:

I certify that the statements in response to the information requested above (including that the employee actually worked the dates and total hours claimed on this form) are true, complete and correct to the best of my knowledge. Further, I certify that the employee named above is not the owner of the business and is not related to the employer. I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to criminal prosecution and civil remedies.

14. Supervisor's Signature: ______________________ 15. Date: ____________

Supervisor's Printed Name: ______________________

For OWCP Use Only Below This Space:

Percentage Allowed: _____ %

Total Amount This Payment: $ ______________

Authorized by: ______________________ Date: ____________

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.) is 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 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, 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/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.

We are authorized to request a taxpayer identification number (TIN) or Social Security Number (SSN) under the Debt Collection Improvement Act of 1996, Title 31 U.S.C. amended section 7701(c)(1), which mandates us to require regulated entities and persons who are doing business with a Federal agency to furnish a TIN or SSN. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law.

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 be 30 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. 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 1240-0018. Note: please do not send the completed form to this office.

NOTICE

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 form instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.