Stipulation Approval Request

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

You must use this form to request a District Director compensation order approving joint stipulations.
You must attach the signed stipulations you want approved.

OMB No.: 1240-0058
Expires: 03/31/2023

Submit form to the OWCP/DFELHWC Central Mail Receipt site at the following address:
U.S. Department of Labor, Office of Workers' Compensation Programs
DFELHWC
400 West Bay Street, Suite 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.gov/portal/

1. Date of Accident/Illness:	2. Carrier's No.	3. OWCP No.

4. Name of Injured Worker and Claimant *if other than injured worker*

5. Average Weekly Wage:	6. Compensation Rate

7. These Stipulations Include *(check all that apply):*

☐ Compensation ☐ Medical Treatment ☐ Attorney Fees

8. ENTER ALL PAYMENTS TO BE MADE PURSUANT TO THESE PROPOSED STIPULATIONS

TYPE OF DISABILITY a.	FROM (Mo., day, yr.) b.	THROUGH (Mo., day, yr.) c.	AMOUNT PAID PER WEEK d.	NUMBER OF WEEKS PAID e.	TOTAL f.

9. Amount Due for Attorney fee:

10. Check if Additional Compensation will be paid as a result of these Stipulations: ☐

11. Additional Information *(optional):*

Print Reset

Form LS-9

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 burden for this collection of information is estimated to average 20 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 required to obtain a compensation order approving stipulations from the Office of Workers' Compensation Longshore Program. See 20 C.F.R. 702.315(a). 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-3524, Washington, D.C. 20210 and reference the OMB Control Number. Note: Please do not return the completed LS-9 to this office.

PRIVACY ACT STATEMENT

The following information is provided in accordance with the Privacy Act of 1974, as amended, 5 USC 552a. (1) This collection of information is authorized under the Longshore and Harbor Workers' Compensation Act (LHWCA) and its extensions. (2) The information will be used to determine whether a compensation order should be issued based on stipulations entered into by the parties to a LHWCA claim. (3) Completion of this form is required to obtain a compensation order approving stipulations from the Office of Workers' Compensation Longshore Program. (4) Disclosures of this information may be made to: the claimant and his or her representative(s); the employer, the insurance carrier or other entity that secured the employer's compensation liability, and their representative(s); the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, authorized or required to render decisions on claims or other matters arising in connection with a claim; Federal, state and local agencies to determine whether benefits are being and have been paid properly and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law; and other individuals, their representatives, and government agencies enforcing a legal obligation for alimony or child support. (5) Failure to provide the information on this form may delay processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits. (6) This information is included in two Systems of Records, DOL/OWCP-3, 4, published at 81 *Federal Register* 25765, 25859-61 (April 29, 2016), or as updated and republished.