# Notice of Employee's Injury or Death

Longshore and Harbor Workers' Compensation Act,
As Extended (see instructions on reverse)

Print Reset

## U.S. Department of Labor

Office of Workers' Compensation Programs
https://www.dol.gov/agencies/owcp/dlhwc

This form should be furnished by the employer to any employee covered by the Longshore and Harbor Workers' Compensation Act or a related law who reports an occupational injury or illness to his/her employer. This form is used to provide written notice of an injury or death. The information will be used to determine entitlement to benefits.

OMB No. 1240-0014
Expires: 10/31/2023

1. Employee's Name (Last, First, Middle)

last first mi.
name

2. Home Mailing Address (Number, Street, City, State, Zip Code)

line1 city
line2 st zip
country United States

3. Date of Birth (Month, Day, Year)

4. Do you think of yourself as:

☐ Male ☐ Transgender man ☐ Genderqueer/gender non-conforming/non-binary
☐ Female ☐ Transgender woman ☐ Another gender
☐ Decline to answer

5. Social Security Number (Required by Law)

6. Home Telephone (Area code + Number

7. Name and Address of Employer (Number, Street, City, State, Zip Code, Country)

name
line1 city
line2 st zip
country United States

7a. Injury is reported under the:

8. Employee's Job Title

9. Date of Injury (Month, Day, Year)

10. Hour of Injury

11. Exact place where accident occurred (Street address, city, town, country) (For Longshore also include: name of vessel, pier, terminal, etc.) (For DBA also include: name of the DOD facility or associated worksite - i.e. base, FOB, camp, etc.)

12. Name of Supervisor at Time of Injury

13. Did Employee Stop Work Due to Injury? ☐ Yes ☐ No

14. If yes, Date Stopped

15. Cause of Injury (Explain in what way the injury or occupational illness was caused by employment)

16. Effects of Injury (Indicate part of body affected or if death occurred)

NOTE: **If reporting injury, employee signs Item 17; if reporting death, claimant or representative signs Item 18**

17. I am requesting the employer named in item 7 to provide me appropriate compensation and medical care for my injury, and I hereby make claim for all benefits to which I may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

Signature of Employee Date Telephone No.

18. Request is hereby made to the employer named in Item 7 to provide appropriate death benefits to the survivors of the employee named in Item 1, and a claim is hereby made for those death benefits to which these survivors may be entitled under the Longshore and Harbor Workers' Compensation Act, or a related law.

Signature of Employee Date Telephone No.

19. This notice is being personally delivered, or mailed, to the employer named in Item 7 (or his/her representative) and a copy is being sent to the District Director of the Office of Workers' Compensation Programs by the party named in either Item 17 or 18 on this date.

Date

**IMPORTANT NOTICE**

Section 31(a)(1) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 931 (a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

## INSTRUCTIONS TO EMPLOYEE

**IT IS IMPORTANT THAT WRITTEN NOTICE OF EMPLOYMENT-CAUSED INJURY OR ILLNESS BE GIVEN PROMPTLY TO THE EMPLOYER AND THE DISTRICT DIRECTOR IN THE LOCAL OFFICE OF THE OFFICE OF WORKERS' COMPENSATION PROGRAMS, U.S. DEPARTMENT OF LABOR.**

Written notice needs to be given so that the District Director may see that an employee in case of injury, or his or her survivors in case of death, receives all the benefits to which they may be entitled. No benefit need be paid under the appropriate law unless a notice of injury or death is filed. [33 U.S.C. 912 (a)]

**WHO FILES**

Injured employees or survivors of employees whose deaths were due to employment covered by the Longshore and Harbor Workers' Compensation Act, or its extensions.

Those Acts which extend the provisions of the Longshore and Harbor Workers' Compensation Act are:

•Defense Base Act •Nonappropriated Fund Instrumentalities Act •Outer Continental Shelf Lands Act

**WHEN TO FILE**

As soon as possible or within 30 days after the date of injury or death, or

Within 30 days after the employee or survivor first became aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of a relationship between the injury or death and the employment, or

In the case of an occupational disease which does not immediately result in a disability or death, within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability, or

In the case of hearing loss, within 30 days after receipt by an employee of an audiogram, with the accompanying report thereon, indicating that the employee has suffered a loss of hearing.

**WHY FILE**

The employer needs to have notice so that it or its insurance carrier may see that medical care is given promptly and compensation payments for loss of income may be provided without delay.

**WHERE TO FILE**

Give copy to the District Director at the following address:

Please be sure to include the OWCP Case Number and mail to the OWCP/DFELHWC Central Mail Receipt site at the following address:
U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Federal Employees', Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

Or upload the form directly to the case file using our Secure Electronic Access Portal (SEAPortal).

Access the SEAPortal directly at https://seaportal.dol.gov/portal/

### PRIVACY ACT STATEMENT

The Privacy Act of 1974 as amended (5 U.S.C. 552a), section 901 of Title 33 to the US Code and 20 CFR 702.211 authorize collection of this information. The purpose of this information is to determine eligibility (LHWCA). Completion of this form is not mandatory; however, failure to provide the information may result in the loss of compensation benefits. Additional disclosures of this information may be to: (1) the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (2) physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (3) the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect of the claim or other matter arising in connection with the claim. (4) Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (5) Disclosure of the claimant's Social Security Number (SSN) or tax identifying number (TIN) on this form is mandatory. (6) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits. We are authorized to collect a Social Security Number (SSN) under Executive Order 9397 (November 22, 1943) to help identify individuals in agency records and keep records accurate because other people may have the same name and birth date.

### 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 form is optional, however furnishing the information is required in order to obtain and/or retain benefits. (20 CFR 702.211). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestion 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.

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**