Employer's First Report of Injury or Occupational Illness

(See instructions on reverse)

U.S. Department of Labor

Office of Workers' Compensation Programs

Print Reset

OMB No. 1240-0003
Expires: 02/29/2024

1. OWCP No.	2. Carrier's No.	3. Date and Time of Accident (mm/dd/yyyy) (hh:mm am/pm)	**Is this an Amended filing?** If yes, list Box(es) Amended (i.e. Box 12, 19, etc.) ☐ **Yes** ☐ **No**

4. Name of injured/deceased employee (Type or print - first, M.I., last)

First Name | M.I. | Last Name | Telephone

5. Employee's address (No., street, city, state, ZIP, country)

Street:

City: **St:** **Zip:** **Ctry:**

6. Injury is reported under the following Act (Mark one)

- A ☐ Longshore and Harbor Workers' Compensation Act
- B ☐ Nonappropriated Fund Instrumentalities Act
- C ☐ Outer Continental Shelf Lands Act
- D ☐ Defense Base Act

1. Contracting Agency

2. Prime Contract #

3. Sub-Contract #

7. Indicate where injury occurred (Longshore Act only) (Mark one)

- A ☐ Aboard vessel or over navigable waters
- B ☐ Pier/Wharf
- C ☐ Dry dock
- D ☐ Marine terminal
- E ☐ Building way
- F ☐ Marine railway
- G ☐ Other adjoining area

8. Sex ☐ M ☐ F

9. Date of birth (mm/dd/yyyy)

10. Social security no. (Required by law)

10a. Nationality (DBA only)

11. Did injury cause death? ☐ No ☐ Yes - If yes, skip to 16

12. Did injury cause loss of time beyond day or shift of accident? ☐ Yes ☐ No

13. Date and hour employee first lost time because of injury — Date (mm/dd/yyyy) Time (hh:mm am/pm)

14. Did employee stop work immediately? ☐ Yes ☐ No

15. Date & hour empl returned to work (mm/dd/yyyy) (hh:mm am/pm)

16. Was employee doing usual work when injured/killed? (if no, explain in Item 26) ☐ Yes ☐ No

17. Did injury/death occur on employer's premises? ☐ Yes ☐ No

18. Dept. in which employee normally works(ed)

19. Occupation

20. Date and hour pay stopped (mm/dd/yyyy) (hh:mm am/pm)

21. Which days usually worked per week? (Mark (X) days) S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐

22. Date employer or foreman first knew of accident. (mm/dd/yyyy) (hh:mm am/pm)

23. Wages or earnings (include overtime, allowances, etc.)

a. Hourly	
b. Daily	
c. Weekly	
d. Yearly	

24. 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.)

25. How was knowledge of accident or occupational illness gained?

26. **Describe in full how the accident occurred** (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.)

27. **Nature of Injury** (Name part of body affected - fractured left leg, bruised right thumb, etc.) If there was amputation of a member of the body, describe.

28a. Has medical attention been authorized? ☐ Yes ☐ No	28b. LS-1 issued? Yes ☐ No ☐	29. Enter date of authorization.	30. Was first treating physician chosen by employee? ☐ Yes ☐ No	31. Has insurance carrier been notified? ☐ Yes ☐ No

Name of:	**Address - Enter number, street, city, state, zip code**
32. Physician	
33. Hospital	
34. Insurance Carrier	
35. Employer	
36. Employer's Business	37. Signature of person authorized to sign for employer — Phone number

38. Official title and phone number of person signing this report — Name of person signing this report

39. Date of this report (mm/dd/yyyy)

This report is required by 33 U.S.C. 930(a) and must be filed with the U.S. Department of Labor, Office of Workers' Compensation Programs, Division of Federal Employees', Longshore and Harbor Workers' Compensation by electronic submission via OWCP web portal, facsimile or Central Mail Receipt Site. File form within 10 days from the date of injury or death or from the date the employer first has knowledge of an injury or death. Under the law all medical treatment and compensation must be furnished by the employer or its insurance company. Treatment must be by a physician chosen by the employee, unless the physician is on a list of physicians currently not authorized by the Department of Labor to render medical care under the Act. Compensation payments become due and are payable on the 14th day after the employer first has knowledge of the injury or death. Penalties may be charged for failure to comply with provisions of the law. The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. For further information, visit our website at https://www.dol.gov/agencies/owcp/dlhwc/lscontac

REPORTABLE INJURY – Any accidental injury which causes loss of one or more shifts of work or death allegedly arising out of and in the course of employment, including any occupational disease or infection believed or alleged to have arisen naturally out of such employment, or as a natural or unavoidable result from an accidental injury. If the employer controverts the right to compensation it must also file a notice of controversion with the District Director within 14 days after it has knowledge of the allged injury or death.

Item 6 – A. Longshore and Harbor Workers' Compensation Act covers employees injured while engaged in maritime employment upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, or building a vessel); - employees injured upon the navigable waters of the United States and other described areas who at the time of injury were engaged in maritime employment and are not otherwise specifically excluded under the Act (33 U.S.C. 902).

B. Nonappropriated Fund Instrumentalities Act covers employees of nonappropriated fund instrumentalities of the Armed forces, e.g., post exchanges, motion picture service, etc.

C. Outer Continental Shelf Lands Act covers employees of private employers engaged in operations conducted on the Outer Continental Shelf for the purpose of exploring for, developing, removing, or transporting by pipeline the natural resources of submerged lands.

D. Defense Base Act covers any employment (1) at military, air, and naval bases acquired by the United States from foreign countries; (2) on lands occupied or used by the United States for military or naval purposes outside the continental limits of the United States; (3) upon any public work in any Territory or possession outside the continental United States under a contract of a contractor with the United States; (4) under a contract entered into with the United States where such contract is to be performed outside the continental United States and at places not within the areas described in (1), (2), and (3) above for the purpose of engaging in public work; (5) under certain contracts approved and financed by the United States under the Mutual Security Act of 1954, as amended; and (6) in the service of American employers providing welfare or similar services for the benefit of the Armed Forces outside the Continental United States.

Item 24 – "Exact place where accident occurred" requires the nearest street address, city and town. In addition -

- If on a vessel,
  Give place on vessel where injury happened (Deck, hold, tweendeck, engine room, etc.) Name of vessel
- If either on an adjoining pier, wharf, dry dock, terminal building way, marine railway, or other area customarily used in loading, unloading, repairing, or building a vessel

  Name or number of pier, dry dock, marine railway, etc.
  Name of the terminal or shipyard
  Nearest street address – City and State
- If injury or death is reported under the Defense Base Act, give the name of the country where injury or death occured.
- If on the Outer Continental Shelf,
  Give drilling site and block number
  Area name (e.g. West Delta Area)
  Federal Lease Number, State Lease Number
  Distance from and name of nearest land,
  name of State
- If DBA, give the City, Country, Base, Camp, DOD facility or any additional information that will assist with determining exact location.

SUBMISSION

The form can be uploaded via SEAPortal (https://seaportal.dol.gov/portal/) or mailed to us at: 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

PRIVACY ACT OF 1974 NOTICE

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) you are hereby notified that (1) the Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants. (2) Information which the Office has will be used to determine eligibility for the amount of benefits payable under the LHWCA. (3) Information may be given to the claimant or his/her representative. (4) Information may be given to 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. (5) Information may be given to 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 to the claim or other matter arising in connection with the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA, to determine whether benefits are being or have been paid properly, and, where appropriate, to pursue salary/ administrative offset and debt collection actions required or permitted by law.

NOTE: FILING THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE COMPENSATION ACT. Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails to submit this report when required or knowingly or willfully makes a false statement or misrepresentation in this report shall be subject to a civil penalty based on amounts outlined in the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, for each such failure, refusal, false statement, or misrepresentation. [33 U.S.C.930(e)] This report shall not be evidence of any fact stated herein in any proceeding in respect to any such injury or death on account of which the report is made. [33 U.S.C. 930(c)]

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. Completion of this form is mandatory. 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, N.W., Room S-3229, Washington, DC 20210.
DO NOT SEND THE COMPLETED FORM TO THIS OFFICE