

Attachment D
Form OCAS-1

Form Approved:

**Statement by the Claimant Closing the Record on a NIOSH Dose Reconstruction under the
Energy Employees Occupational Illness Compensation Program Act**

I, _____ (NIOSH Tracking Number XXXX), a claimant under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), certify that in signing this form, I have read, understand, and affirm that the following statements are true:

- 1) I am not in possession of any additional information that has not already been provided to NIOSH for completing a dose reconstruction to estimate the radiation doses incurred by the employee; and,
- 2) I understand that NIOSH will forward a final dose reconstruction report to the Department of Labor (DOL), so that DOL can continue adjudication of my claim and produce a recommended decision and then a final decision to accept or reject my claim; and,
- 3) I understand that NIOSH can not forward the dose reconstruction report to DOL for adjudication without receipt of a properly signed OCAS-1 form within 60 days of my receipt of this form and NIOSH may administratively close the dose reconstruction and notify DOL of this action if I do not provide a properly signed OCAS-1 form within this 60-day period; and,
- 4) I understand that my opportunity to seek a review of the NIOSH dose reconstruction occurs when my claim is with DOL and occurs only after DOL produces a recommended decision to deny my claim; and,
- 5) By signing this form, I do NOT certify or imply that I agree with NIOSH decisions indicated in the draft NIOSH dose reconstruction report concerning how NIOSH has used or not used information I have provided for the dose reconstruction; and,
- 6) By signing this form, I do NOT certify or imply that I agree with the findings of the NIOSH dose reconstruction and I understand that I may seek review of this NIOSH dose reconstruction after DOL makes a recommended decision on my claim.

Notice: I affirm that the information provided on this form is accurate and true. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Signature _____ Date _____

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, gathering the information needed, and completing the form. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to CDC Reports Clearance Officer, 1600 Clifton Road, MS-D-74, Atlanta, GA 30333; ATTN:PRA 0920-0530. Do not send the completed interview form to this address. Please complete and return this form using the enclosed pre-addressed, postage-paid envelope. Persons are not required to complete this form unless a currently valid OMB number is displayed.