Attending Physician's Supplementary Report

(Longshore and Harbor Workers' Compensation Act, As Extended)

Print Reset

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

INSTRUCTIONS: Use this form to make progress reports and to make a final report when the patient is discharged. Progress reports should be submitted about every thirty days, the original to the District Director (See Item 19. on page 2) and one copy to the insurance carrier or self-insured employer. Please answer all questions fully. If a question is not applicable, enter "NA". The exact point of amputation or other permanent partial impairment must be known to determine compensation the injured is entitled to receive. If preferred, physician may submit a narrative report covering all information requested on this form. Use "Remark" on page 2 of form if more space is needed for any answer.

OMB No. 1240-0014
Expires: 11/30/2026

OWCP No.

Carrier's No.

1. Type of Report (Mark X one)
☐ Progress ☐ Final

2. Date of Injury (mm/dd/yyyy) Injured Employee's Telephone Number

3. Name of Injured employee
First name: M.I.
Last name:

4. Employee's home address
Line 1: City:
Line 2: State: Zip Code:
Country: United States

5. Name of employer

6. Name of insurance carrier

7a. Have you filed a previous report giving history?
☐ Yes- skip to Item 8 ☐ No-Answer 7b and 7c

7b. State how many injuries occurred and give source of information. (If claim is for occupational disease, include occupational history and date of onset of related symptoms)

7c. Was employee previously under the care of another physician for this injury?
☐ No ☐ Yes- Give Physician's name and address and reason for transfer

8. Is there any history or evidence of pre-existing injury, disease or physical impairment?

9a. Present condition (include diagnosis, subjective complaints, objective findings, and any changes of condition since last report.)

9b. If employee was hospitalized since last report, indicate and give name and address of hospital.

10a. Describe treatment provided

10b. Date of first treatment

10c. Date of most recent treatment

10d. Has treatment been terminated?
☐ No ☐ Yes- Indicate reason

10e. Are you continuing treatment?
☐ No ☐ Yes

10f. If treatment is continuing, estimate probable duration

This report is authorized by 33 U.S.C. 907(b). While you are not required to respond on this form, your cooperation is needed to insure that the injured's workers' compensation case is properly processed by the U.S. Department of Labor. This form is used to request medical information which will be used to determine an injured worker's entitlement to compensation and medical benefits.

11. Will the injury result in permanent restriction, total or partial loss of function or a part or member, or permanent disfigurement of the head, face, or neck, or some other part of the body which will handicap the employee in securing or maintaining employment?

☐ No ☐ Yes-Describe

12. Is employee working?	13. When do you estimate employee can
☐ Yes ☐ No	a. Resume limited work of any kind? Date (mm/dd/yyyy) b. Resume regular work? Date (mm/dd/yyyy)

14. If employee is unable to do his/her regular work, but can do limited work, specify work limitations due to this injury.

15. In your opinion, was the occurrence described above (or in the previous report which gave this information) the competent producing cause of the injury and disability? ☐ Yes ☐ No

16. Is rehabilitation treatment or service or evaluation recommended?	17. If rehabilitation treatment or services or evaluation is recommended, has referral been made?
☐ Yes- Explain ☐ No- Explain	☐ Yes- To whom? ☐ No- Explain

18. Remarks	19. Upload your report to https://seaportal.dol.gov/portal/ (preferred method) or mail to:
	U.S. Department of Labor **Office of Workers' Compensation Programs** **Division of Longshore and Harbor Workers' Compensation** **400 West Bay Street, Suite 63A, Box 28** **Jacksonville, FL 32202**

20. Name of attending physician (Type or Print)	21. Signature of physician

22. Address of Physician	23. Telephone Number of Physician	24. Date of Report
Line 1: City: Line 2: State: Zip Code: Country: United States		

TO SUBMIT FORMS TO THE DEPARTMENT OF LABOR

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

Or upload (preferred method) 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 33 U.S.C. 907 (b) authorize collection of this information. The purpose of this information is to determine an injured worker's entitlement to compensation and medical benefits under the Longshore and Harbor Workers' Compensation Act (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 to 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 under the LHWCA 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. (5) 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.

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 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. (33 U.S.C. 907 6). Send comments regarding this burden estimate or any 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.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.