INSTRUCTIONS FOR SUBMITTING WORKERS' COMPENSATION FORMS

	FORM	PREPARED BY	FORWARDED TO
____	**LS-201**	Injured Employee	NAF-HR within 24 hrs of completing the paperwork
			***** ***Must be completed by the employee in his/her own words.*** *****
____	**AF 786**	Injured Employee	NAF-HR within 24 hrs of completing the paperwork
			***** ***Authorization for Release of Medical Information.*** *****
____	**LS-202**	Supervisor/Manager	NAF-HR within 24 hrs of completing the paperwork
			***** ***Must be completed within 24 hrs of notice of an injury*** *****
			***** ***Supervisor or manager of facility MUST sign Block #37.*** *****
____	**LS-1**	Supervisor/Physician	NAF-HR within 24 hrs of completing the paperwork and Injured employee takes to treating Physician
		***** ***Used for initial visit/treatment….NOT for follow-up visits/appointments.*** *****	
____	**LS-204**	Attending Physician	Human Resources Office
			***** ***Only used for FOLLOW-UP visits/appointments.*** *****
____	**LS-210**	Supervisor	Human Resources Office
***** ***Only need if release date/return to work date is not known as time LS-202 is submitted.*** *****			

IMPORTANT!

Per Air Force Services Agency (AFSVA) all documentation should be completed and forwarded to the Human Resources Office within ***24 hours*** *of injury or knowledge of injury to avoid delays or conflicts.*

If any witnesses were present at the time of injury, have witnesses submit statements in MFR format and submit with all other documentation.

If an employee is injured at work but does not wish to see the doctor and continues to work, please have the employee complete an LS-201, Notice of Employee's Injury or Death, section 16, annotating their refusal to seek medical attention at the time of injury, also ask the employee to write a statement in MFR format stating the same. Submit this documentation to the Human Resources Office.

If you have any questions, comments, or concerns pertaining to this matter, please don't hesitate to call David Perez 310-653-5085 or Morgan Burton 310-653-8943.

PATIENT'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(USAF NONAPPROPRIATED FUND WORKERS' COMPENSATION PROGRAM)
(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 33 U.S.C. 903, Longshoremen's and Harbor Workers' Compensation Act; 10 U.S.C. 8013; and 44 U.S.C. 3101.
PRINCIPAL PURPOSE: To obtain information on present and past injuries and illnesses of employees.
ROUTINE USES: Used to determine what benefits, if any, may be due an employee under the Longshoremen's and Harbor Workers' Compensation Act as extended by the Nonappropriated Fund Instrumentalities Act (5 U.S.C. 8171). Information furnished may be disclosed to any DOD component or part thereof, and upon request, to other Federal, state and local government agencies in the pursuit of their official duties and to the Department of Labor. The information may also be used for other lawful purposes including those indicated below, law enforcement and or litigation.
DISCLOSURE IS MANDATORY: Failure to provide the information may result in reduction and/or delay of potential benefits.

1. I authorize and direct any physician who has examined and/or treated me or who may examine and/or treat me after the date of signature on this authorization or any medical facility where I have been examined and/or treated or at which I may be examined and/or treated after the date of signature on this authorization to provide to any authorized representative of the United States Air Force any information regarding my physical condition and/or treatment rendered, and to allow said representative to inspect, review and/or make copies of any and all medical records concerning my condition.

2. I authorize and direct any of my prior employers who may have records of my physical condition or insurance carriers which may have received and processed my prior claims for benefits to provide such records for inspection, review and/or copying by said representative.

3. I authorize my current employer to release information on my claim to any claim index bureau or similar organization which maintains such information for historical, analytical, and/or investigative purposes.

4. A copy of this authorization may be accepted and honored as if it were the original.

CASE NUMBER	EMPLOYEE'S NAME *(Print or type)*
DATE	EMPLOYEE'S SIGNATURE

AF IMT 786, 19981101, V2 PREVIOUS EDITION IS OBSOLETE.

U.S DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs
PRIVACY ACT OF 1974 NOTICE

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 LS.C. 522a), you are hereby notified that: (1) The Longshoremen's and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office recieves and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the suject matter of the claim, so long as such agencies or persons have recieved the consent of the individual claimant, or have complied with the provisions of 20 CFR 702. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclousure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION

Request for Examination and/or Treatment Reset Print

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

Part A - Authorization | **OMB No. 1240-0029**

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the **employee's choice** (*See item below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course or employment.

Mark either box A or B in item 7. The original and two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the Office of Workers' Compensation Programs and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:

A ☐ Longshore and Harbor Workers' Compensation Act

B ☐ Defense Base Act

C ☐ Nonappropriated Fund Instrumentalities Act

D ☐ Outer Continental Shelf Lands Act

2. Name and address of physician or medical facility authorized to provide medical service

* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diagnose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name:

line1: city:

line2: st:

3. Employee's Name	**4. Date of Injury (mm/dd/yyyy)**	**5. Occupation**

6. How accident or illness occurred

7. You are authorized to provide medical services to the employee as follows:

A ☐ If you believe the condition is related to the injury or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.

B ☐ If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

You are requested to submit a written report of first treatment within 10 days to the Office of Workers' Compensation Programs. See item 12 below (See back of this form for Instructions as to medical report and the submission of your charges).

8. Signature and title of authorizing official (Sign all copies)

9. Name and address of employer

name:

line1: city:

line2: st:

10. Telephone (Area code and local number)

(210) 395-7269

11. Date authorized (mm/dd/yyyy)

12. Send one copy of your report 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

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent

name: Air Force Insurance Fund

line1: 2261 Hughs Avenue, Suite 156 city: JBSA Lackland

line2: st: TX 78236-9854

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 65 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 (20CFR 702.419). 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 C-4319, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Part B - Attending Physician's Report of Injury and Treatment

Instructions To Physician: This initial report should be completed and submitted within 10 days. Mail the original to the Office of Workers' Compensation Programs (see Item 12 for address), and a copy to the company listed In Item 13. Subsequent reports should be made regularly on form LS-204 and/or in narrative form while the employee is in your care. Please read item 7 on the front of this form.

14. What history of injury or disease did employee give you?

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

☐ No ☐ Yes - Please describe

16. What are your findings (include results of x-rays, laboratory tests, etc.)?

17. What is your diagnosis?

18. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain your answer if there is doubt.)

☐ Yes ☐ No

19a. Did injury require hospitalization? ☐ No ☐ Yes - Complete b, c, d

b. Name of hospital

c. Date admitted (mm/dd/yyyy)

d. Date discharged

20. Is additional hospitalization required?

☐ Yes ☐ No

21. Surgery (If any, describe type)

22. Date surgery performed (mm/dd/yyyy)

23. What type of treatment did you provide other than hospitalization or surgery?

24. What permanent effects of the injury, if any, do you anticipate?

25. Date of first examination (mm/dd/yyyy)

26. Date(s) of treatment (mm/dd/yyyy)

27. Date of discharge from treatment (mm/dd/yyyy)

28. Period of disability (if termination date unknown - so indicate)

Total disability: From To

Partial disability: From To

29. Date employee able to resume work

To light work

To regular work

30. If employee is able to resume work, has he/she been advised? ☐ No ☐ Yes - Furnish date advised (mm/dd/yyyy)

31. If employee is able to resume only light work, indicate physical limitations and the type of work which can reasonably be performed with these limitations.

32. Remarks and recommendation for future care, if indicated.

33. Do you specialize? ☐ No ☐ Yes - State specialty

34. Signature and typed name of physician

35. Address and phone number

36. Physician's Federal Tax ID number

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

38. Medical bill (Charges for your services may be presented in the space below or on a standard billing form.)

Date or period of treatment	Services and supplies must be itemized	Qty. or No.	Unit price Cost	Per	Amount
				Total	

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
www.dol.gov/owcp/dlhwc/index.htm

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

1. Employee's Name (Last, First, Middle)
   name: last / first / mi.

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. Sex: Male / Female

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)
   name
   line1 / city
   line2 / st / zip
   country United States

8. Employee's Job Title

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

10. Hour of Injury

11. Place where Injury Occurred

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 original copy to employer and send one copy to the District Director at the following address:

District Director
U.S. Department of Labor
Office of Workers' Compensation Programs (OWCP)
Division of Longshore and Harbor Workers' Compensation

FAILURE TO GIVE WRITTEN NOTICE MAY RESULT IN SOME LOSS OF BENEFITS.

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 C-4315, Washington ,D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

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

1. OWCP No.
2. Carrier's No.
3. Date and Time of Accident (mm/dd/yyyy) (hh:mm am/pm)
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 (See instructions on reverse). This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.
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)

Form LS-202
Rev. April 2012

This report is to be filed in duplicate with the District Director in the appropriate district office of the Office of Workers' Compensation Programs and is required by 33 U.S.C. 930(a). 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.

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 alleged 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

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 not to exceed $11,000 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. Use of this is optional, however furnishing the information is required in order to obtain and/or retain benefits (33U.S.C. 930(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, N.W., Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

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
www.dol.gov/owcp/dlhwc/index.htm

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

FOR OFFICE USE

OWCP No.

Carrier's No.

1. Type of Report (Mark X one) ☐ Progress ☐ Final	2. Date of Injury (mm/dd/yyyy) Telephone
3. Name of Injured employee	4. Employee's home address
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?

☐ Yes ☐ No

13. When do you estimate employee can
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? ☐ Yes- Explain ☐ No- Explain

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

18. Remarks

19. Send the original of your report to:

Office of the District Director
U.S. Department of Labor
Office of Workers' Compensation Programs

20. Name of attending physician (Type or Print)

21. Signature of physician

22. Address

23. Telephone No. (Area Code)

24. Date of Report

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 C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

Employer's Supplementary Report of Accident or Occupational Illness

Print | Reset

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

Notice: This Report should be filed promptly with the District Director in every case in which (1) Form LS-202 does not show date injured employee returned to work, and (2) each time injured employee has returned to work and later becomes disabled for work (33 U.S.C.930(b) if the information is not already reported via Form LS-206 or LS-208. If the employee was disabled for work more than 3 days, compensation payments should be reported on Forms LS-206 and LS-208. Medical reports must be sent to the District Director promptly following first treatment and thereafter while treatment continues. Please type or print all information. (if additional space is needed, use back of form.) The information will be used to determine entitlement to benefits.

OMB No. 1240-0003

For Office Use

1. OWCP No.

2. Carrier's No.

3. Name of injured employee (First, middle initial, last)

4. Date of accident (Month, day, year)

5. Address of injured employee (Number and Street, City, State, ZIP code)

6. Name and address of your insurance carrier

7. Initial Period of Disability (Use Inclusive Dates for a and b)

a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

8. If this report covers a period of disability after the date shown in item 7c. state each subsequent period of disability. Use inclusive dates for a. and b.

a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

9. Did employee receive medical attention?

a. ☐ Yes - Give dates, names and addresses of doctors and hospitals providing treatment.

b. ☐ No - Explain

10. Was employee treated by his or her choice of physician?

☐ Yes ☐ No

11. Was form LS-1 given to employee when injury was reported to you?

☐ Yes ☐ No

12. Name of employer (Firm Name)

13. Employer's address (Number and Street, City, State, ZIP code)

14. Signature of person authorized to sign for employer

15. Name, official title and phone number of person signing

16. Date of report (month, day, year)

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. (33 U.SC.930(b)). 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 C-4319, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

MISHAP DATA WORKSHEET

This form contains personal information protected by the Privacy Act of 1974. Form will be safeguarded from unauthorized disclosure and will be disposed of according to AFI 33-332.

FROM *(Supervisor)*	TO *(Unit Safety Representative)*	TO *(Unit Commander)*	TO *(Wing Safety)*

I. MISHAP DATA INFORMATION *(To be filled in by the supervisor and sent to Unit Safety Rep, Commander, and Safety Ofc within 5 workdays after the mishap.)*

NAME *(Last, First, Middle Initial)*	GRADE	SSN	AGE	SEX	AFSC/JOB SERIES	UNIT/OFFICE SYMBOL/DUTY PHONE

DATE OF MISHAP / TIME OF MISHAP	DUTY STATUS *(At time of mishap)*	AEF ASSIGNED (1-10)	BEEN DEPLOYED IN LAST 365 DAYS	MISHAP OCCURRED
DATE OF MISHAP TIME OF MISHAP	☐ ON DUTY ☐ OFF DUTY ☐ PERM PARTY ☐ STUDENT	☐ YES ☐ NO AEF NUMBER ____	☐ YES ☐ NO DAYS DEPLOYED ____	☐ ON BASE ☐ OFF BASE WEATHER ____ LIGHT CONDITIONS

DISPOSITION OF INDIVIDUAL: (CHECK ALL THAT APPLY)	WITNESSED?	EXACT LOCATION WHERE MISHAP OCCURRED *(Bldg #, Street Name, Miles from Base/Installation)*
☐ NO MEDICAL TREATMENT NEEDED OR SOUGHT ☐ TREATED AND RELEASED BACK TO REGULAR DUTY ☐ RETURNED TO LIMITED DUTY FOR ____ NUMBER OF DAYS ☐ PLACED ON QUARTERS/CON LEAVE FOR ____ NUMBER OF DAYS ☐ ADMITTED TO HOSPITAL FOR ____ NUMBER OF DAYS	☐ YES ☐ NO WITNESS NAMES	

TYPE OF INJURIES RECEIVED *(i.e., Bruise, Fracture, Sprain, etc.)*	LOCATION AND PARTS OF BODY INJURED *(i.e., Left Leg, Head, Right Ankle, etc.)*
TREATMENT RECEIVED *(Includes Stitches, Casts, etc.)*	MEDICATIONS PRESCRIBED

PROPERTY DAMAGE

PROPERTY DESCRIPTION	GMV/SPV/PMV DESCRIPTION *(Year, Make, Model)*	GMV REGISTRATION NO

DAMAGE DESCRIPTION	ESTIMATED COST	SEATBELT/HELMET USED	ALCOHOL INVOLVED	MSF TRAINED
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
NON AIR FORCE PROPERTY DAMAGE	**ESTIMATED COST**	**SPEEDING**	**POSTED SPEED**	**SPEED TRAVELED**
		☐ YES ☐ NO	____ MPH	____ MPH

PROVIDE A CONCISE SUMMARY OF THE MISHAP*(Who, What, When, Where, and Why) (Indicate the cause) (If more space is needed, continue on reverse)*

INDICATE THE CORRECTIVE ACTION(S) TAKEN TO PREVENT RECURRENCE *(If more space is needed, continue on reverse)*

DATE	SUPERVISOR SIGNATURE

II. UNIT SAFETY REPRESENTATIVE, UNIT COMMANDER, AND SAFETY OFFICE REVIEWS AND COMMENTS

UNIT SAFETY REPRESENTATIVE REVIEW AND COMMENTS

DATE	SIGNATURE

II. UNIT SAFETY REPRESENTATIVE, UNIT COMMANDER, AND SAFETY OFFICE REVIEWS AND COMMENTS -- *CONTINUED*

UNIT COMMANDER REVIEW, CONCURRENCE, AND COMMENTS

DATE	SIGNATURE

SAFETY OFFICE REVIEW AND COMMENTS

NOT REPORTABLE IAW:

SAS REPORT NUMBER:

DATE	SIGNATURE

ADDITIONAL REMARKS OR COMMENTS *(Summary of Mishap or Corrective Action Taken)*

DECLINATION OF MEDICAL TREATMENT

I, ______________________________, have been informed that I am entitled to
(PRINT NAME)

medical treatment of any job related injury that may have been suffered while in the performance of my duties. I have elected to decline medical treatment at this time for my injury incurred as a result of a job-related accident on ___________________________.
(DATE)

_______________________________ _______________________________
(EMPLOYEE SIGNATURE) (DATE)

_______________________________ _______________________________
(SUPERVISOR SIGNATURE) (DATE)

<u>NOTE</u>: Attach to the completed LS-201, Notice of Employee's Injury or Death, and LS-202, Employer's First Report of Injury or Occupation Illness, and forward to HRO.