INSTRUCTIONS FOR SUBMITTING WORKERS' COMPENSATION FORMS

	FORM	PREPARED BY	FORWARDED TO
______	LS-201	Injured Employee	Human Resources Office
			***** *Must be completed by the employee in his/her own words.* *****
______	LS-202	Supervisor/Manager	Human Resources Office
			***** *Supervisor or manager of facility MUST sign Block #37.* *****
______	AF 786	Injured Employee	Human Resources Office
			***** *Authorization for Release of Medical Information.* *****
______	LS-1	Supervisor/Physician	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 (or next business day) 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.

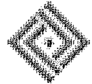
If an employee is injured at work but does not wish to see the doctor and continues to work, please have the employee complete an LS-201, Notice of Employee's Injury or Death, section 16, annotating their refusal to seek medical attention at the time of injury, also ask the employee to write a statement 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 Elena Flores at 653-5084.

Notice of Employee's Injury or Death

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

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



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. Notice is required to obtain a benefit (20 CFR 702.212). 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.

OMB No. 1215-0160

1. Employee's Name (Last, first, middle)
   Last Name ____ First Name ____ M.I. ____

2. Home Mailing Address (Number, street, city, state, ZIP code)
   line 1: ____ city: ____
   line 2: ____ st: ____ zip: ____
   country: ____

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: ____
   line 1: ____ city: ____
   line 2: ____ st: ____ zip: ____
   country: ____

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 parts 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 ____
Print Name ____

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 Compensation Claimant or Representative of Claimant ____ Date ____
Print Name ____

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.

Employer's First Report of Injury or Occupational Illness
(See instructions on reverse - Leave Items 1 and 2 blank)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0031

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 ☐ Defense Base Act
- C ☐ Nonappropriated Fund Instrumentalities Act
- D ☐ Outer Continental Shelf Lands Act

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) *

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.

28. Has Medical Attention Been Authorized? ☐ Yes ☐ No

29. Enter Date of Authorization (mm/dd/yyyy)

30. Was First Treating Physician Chosen by Employee? ☐ Yes ☐ No

31. Has Insurance Carrier Been Notified? ☐ Yes ☐ No

▶ Name		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 Signature

38. Official Title of Person Signing This Report *

Name of Person Signing This Report *

39. Date of This Report (mm/dd/yyyy) 06/24/2008

Form LS-202
Rev. Oct. 1998

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.

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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.

Request for Examination and/or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Part A - Authorization > OMB No. 1215-0066

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the **employee's choice** (*See item 2 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 of employment.

Mark either box A or B in item 7. The original and at least 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 District Director 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.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The information collected will be used to supervise the medical care rendered to injured employees and furnishing the information is mandatory (20 CFR 702.419).

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:
line 1: city: country:
line 2: state: zip:

3. Employee's Name
First Name M.I. Last 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 District Director at the Office named in 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)
name title

9. Name and address of employer ctry:
name:
line 1: city:
line 2: st: zip:

10. Telephone (Area code and local number)

11. Date authorized (mm/dd/yyyy)

12. Send one copy of your report to:

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent
name:
line 1: city:
line 2: st: zip:
country:

Public Burden Statement

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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **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 District Director (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. Your Social Security Number is voluntary and is used for identification purposes only.

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 (mm/dd/yyyy)
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
First Name M.I. Last Name

35. Address
line1:
line2:
city: country:
st: zip:

36. Physician's social security number

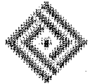
37. Date of this report (mm/dd/yyyy)

38. Medical bill (Charges for your services may be presented in the space below or on your billhead stationery.)

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

Attending Physician's Supplementary Report
(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



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 "Remarks" on page 2 of form if more space is needed for any answer.

OMB No. 1215-0160

FOR OFFICE USE

OWCP No.

Carrier's No.

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

2. Date of Injury (mm/dd/yyyy)

3. Name of injured employee
   First Name M.I. Last Name

4. Employee's home address
   line 1: city:
   line 2: st: zip:

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 injury 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
   name:
   line 1: city:
   line 2: st: zip:
   reasons:

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.
   name:
   line 1: city:
   line 2: st: zip:

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 worker's 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. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

10a. Describe treatment provided

10b. Date of first treatment (mm/dd/yyyy)

10c. Date of most recent treatment (mm/dd/yyyy)

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

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

10f. If treatment is continuing estimate probable duration (mm/dd/yyyy)

11. Will the injury result in permanent restriction, total or partial loss of function of 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 - (mm/dd/yyyy)

a. Resume limited work of any kind Date

b. Resume regular work Date

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 services 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
line 1: city:
line 2: st: zip:

23. Telephone No. (Area Code)

24. Date of report (mm/dd/yyyy)

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing Instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 200210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Employer's Supplementary Report of Accident or Occupational Illness

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Notice: This Report must 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 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. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0031

For Office Use

1. OWCP No.

2. Carrier's No.

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

First Name | M.I. | Last Name

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

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

line 1: | country
line 2:
city: | st: | zip:

6. Name and address of your insurance carrier

city:
st: | zip:

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

a. From (Month, day, year)	b. To (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. To (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)

city:
st: | zip:
country:

14. Signature of person authorized to sign for employer

15. Name and official title of person signing

name:
title:

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

06/24/2008

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**