INSTRUCTIONS FOR SUBMITTING WORKERS' COMPENSATION FORMS

	FORM	PREPARED BY	FORWARDED TO
lice and constitution of the lice and the li	LS-201	Injured Employee ***** <i>Mus</i> i	Human Resources Office t be completed by the employee in his/her own words. *****
Begannings Caran Furnishmen	LS-202	Supervisor/Manager ***** <i>Supe</i>	Human Resources Office ervisor or manager of facility MUST sign Block #37. *****
Rount areas served in the stront dest Abstraction	AF 786	Injured Employee ***** Auth	Human Resources Office porization for Release of Medical Information. *****
	LS-1	Supervisor/Physician ***** Used for initial v	Injured employee takes to treating Physician isit/treatmentNOT for follow-up visits/appointments. *****
**************************************	LS-204	Attending Physician ***** Only	Human Resources Office used for FOLLOW-UP visits/appointments. *****
***** O	_LS-210 Inly need if	Supervisor release date/return to	Human Resources Office work date is not known as time LS-202 is submitted. *****

IMPORTANTI

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

OMB No. 1215-0160

1. Employee's Name (Last, first, middle)		2. Home Mailing Address (Number, street, city, state, ZIP code)				
Last Name First Name	line 1:					
	The state of the s	line 2:	en er en konstituten in de skripter en konster der en de en der de konster en en en en en de konster en de kons En en konstituten in de konster en	st: zip:		
			cou	intry:		
3. Date of Birth (Month, day, year) 4. Sex	Male	5. Social Security Number (Required by Law)		Telephone rea Code + Number		
Security of the security of th	Female	age of the state o	enconductions	aggine the conference of the c		
7. Name and Address of Employer (Number, s	treet, city, state,	ZIP code)	8. Employe	ee's Job Title		
name:	ite a ser en en feldfaltsastet besonst til en ekkel til en ekkelet et begigdest hedd	Эн чение на насъ Бенетна на учения выселена месяния и поличина применяю, попурка и В	ANTONOMINE VENEZO TOTAL AND ANTON	TON TOWN AND REPORTED THE STATE OF BURBLES WANTED AND AN INCIDENT AND A PROTECTION OF STATE OF		
line 1:	city:	(*Paperson) в «Воб повышения возмого в возмого за возмого возмого и царовов надаления в в				
line 2:	st:	indice reversaling Tib: [[record classics from the continue of the continue o		APP AND DESCRIPTION OF THE PROPERTY OF THE PRO		
	country:					
9. Date of Injury (Month, day, year)	10. Hour of Injui	y 11. Place Where	Injury Occurred			
	And determined to the control of the	And the state of t	Charles of The Control State - Incolorate State Charles of State S			
ben generation of the state of	Seamann ummusaaren umetoo eustu		leddidd (god) dae an chapean ac a bhanna a gcandaid dhibh i a bhannann ac mhan a c-ann an bh	disposation on the last on the second and the last and the		
12. Name of Supervisor at Time of Injury			Stop Work Due to 14.	If Yes, Date Stopped		
		Injury?	Yes No	Parket and the control of the contro		
15. Cause of Injury (Explain in what way the ir	niury or occupation	nal illness was caused by	employment)	, and a second s		
erandillikussi vertentika kenteren elem 19-1 lillismili taristik kilologia kasarra a bahan dan santan engendas populas populas kasarra.	or delanization to the section of th	ning arramanga na arramanan da mananinakan kalinarinari kan pahaban 1924 da 2024 da 2024 da 2024 da 2024 da 20	ectivatives existent exist, consistent services existent a consistent which the consistent existence in a	енфикантиния «Изстанорну спинистичностического постанования общений постанований выполняю и общен постанований		
6. Effects of Injury (Indicate parts of body affe						
NOTE: If reporting injury, empl			-			
 1 am requesting the employer named in ite claim for all benefits to which I may be enti- 	led under the Lo	e appropriate compensation and Harbor Work	ers' Compensation Act, or	a related law.		
Signature of Employee	· · · · · · · · · · · · · · · · · · ·		Date	determination and action of the control of		
Print Name						
 Request is hereby made to the employer nation. Item 1, and a claim is hereby made for those Workers' Compensation Act, or a related la 	se death benefits					
Signature of Compensation Claimant or	Representative o	f Claimant	Date	retransitional state of the second and account		
tangan Prantonangangangangangangangangangan		The second of the second secon				
This notice is being personally delivered, o the District Director of the Office of Workers	r mailed, to the e	employer named in Item 7	(or his/her representative)	and a copy is being sent to on this date.		
		i	Date			
		STANT 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 Tin		
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4. Name of Injur	red/Deceased Emp M.l. Last Name	loyee (Ty	rpe or print - first, M.I., la Telephone	ıst)	Averlance Colores	e's Address (No	., street, city, state, 2	ZIP, country) *
					street:	st:	zip:	ctry:
	orted Under the Fol	llowing	7. Indicate Where Injury	•	8. Sex *	payment bearing and the second second	Date of Birth (mm/dd/yyyy) *	Accessed to the second
Act (Mark one	,	?	(Longshore Act only) (N	Mark one)	Пм	∏F	(IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	
	shore and Harbor V pensation Act	Norkers	A Aboard Vessel gable Waters	or Over Navi-	10. Social S	10. Social Security No. (Required by Law) *		
B Defer	nse Base Act		B Pier/Wharf			And the state of t		
<i>D</i> 25.6.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		C Dry Dock		p	ry Cause Death'		
	ppropriated Fund In alities Act	nstru-	D Marine Termina	al	12 Did Ini	·	- If yes, skip to 16 s of Time Beyond	<u></u>
			E Building Way		Day or	r Shift of Accid	ent?	Yes No
D Outer	Continental Shelf I	Lands	F Marine Railway	/	13. Date an	d Hour Employe	e Date	Time
			G Other Adjoining	g Area		e of Injury		hh:mm am/pm)
14. Did Employe immediately	? . [Yes No	15. Date&hour empl reti (mm/dd/yyyy) (hh:mi	urned to work m am/pm)		ployee Doing U Killed? (if no, exp	sual Work When olain in Item 26)	Yes. No
17. Did Injury/De Employer's F			8. Dept. in Which Emplo	yee Normally V	Vorks(ed)	19. Occ	cupation	Mildelands (Annua management description and a program of the company of the comp
20. Date and Ho	our Pav Stopped	No 21. Whic	h Days Usually Worked	Per Week?		I22. Date emplo	ver or foreman first kn	ew of accident.
20. Date and Ho (mm/dd/yyyy)	(nh:mm am/pm)		X) days) S M	T W T	F S	(mm/dd/yyy	yer or foreman first kn y) * (hh:mm am/pm)	
23. Wages or Ea overtime, all	arnings (include owances, etc.)	on re	t Place Where Accident verse). This item should n maritime employment	specify area if	accident		Knowledge of Acci onal Illness Gained?	
a. Hourly	and the state of t	adjoi	ning navigable waters.	k	marea ?			V THE
b. Daily c. Weekly		The state of the s				and the same of th		T DESCRIPTION OF THE PERSON OF
d. Yearly		British Charles Colored Complete Const.	and the second s					And the second s
26. Describe in injured was how they we	n full how the acc doing at the time o ere involved. Give	ident oc If the acc full detail	curred (Relate the ever ident. Tell what happen s on all factors which le	nts which resul ed and how it h d or contributed	ted in the in appened. N I to the acci	jury or occupati ame any object dent.)	onal disease. Tell v s or substances inv	what the olved and tell
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body, descri		i tile						
					and the second s		and the state of the	
28. Has Medical Been Author		29. Ente	er Date of Authorization dd/yyyy)	Physic	irst Treating cian Chosen nployee?		. Has Insurance Carrier Been Notified?	Yes No
➤ Name		Lastronomis	HAN HAN ARTHORNOOCH HUNGAAVE			mber, Street,	City, State, ZIP Co	
32. Physician				A CONTRACTOR OF THE CONTRACTOR				
33. Hospital		eneral de Mariemania e l'anno le come e con l'adrichement de l'anno le come de l'anno l'anno de	A Schauster, integralis erbei demokrater obbergka spendeland plekenne forskylle standeland.	The state of the s				
34. Insurance Carrier *				- AVV				
35. Employer				*	Annual Control of the	The second secon		
*		grant to the composite end grant of a grant		moreovered harman and a management				
36. Employer's Business	driven Fille 2018 Berline I ville Between Green 2 I General reseasement on a service and a service sease			3/. Signat	ture of Perso	<u>n Authorized to</u> Signat	Sign for Employer ure	
38. Official Title of Person Signing This Report *				Name of Pen	son Signing Thi		39. Date of This Report 06/24/2008	(mm/dd/yyyy)

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	
4		

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 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 disease arising out of and in the course of employment.	, and 1. This Authorization is for examination and/or treatment under the workers' Compensation Act marked below:
Mark either box A or B in item 7. The original and at least two copies of the are to be given to the physician. The physician is to complete the medical 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 emanded 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 Department of Labor to provide medical care under the Act.	
Persons are not required to respond to this collection of information unler displays a currently valid OMB control number. The information collected used to supervise the medical care rendered to injured employees and furnishing the information is mandatory (20 CFR 702.419).	
	s, dentists, clinical psychologists, optometrists, osteopathic charges for physical examinations, related laboratory tests, x-rays to
3. Employee's Name 4. Date of injury (r	nm/dd/yyyy) 5. Occupation
First Name M.I. Last Name	
6. How accident or illness occurred	
7. You are authorized to provide medical services to the employee a	e follows:
A If you believe the condition is related to the injury, or the employ necessary for the effects of this injury.	
B If you are in doubt as to whether the condition(s) found on exam the employee, using indicated non-surgical diagnostic studies, a believe the disability is due to the alleged injury. Pending further	nd should promptly advise those listed in item 13 whether you
You are requested to submit a written report of first treatment winnamed in item 12 below (See back of this form for Instructions as	
B. Signature and title of authorizing official (Sign all copies)	9. Name and address of employer ctry:
	name:
name	line 1:
name Stitle 10. Telephone (Area code and local number)	line 2: st: zip:
To reception (Area-bode and local number)	11. Date authorized (mm/dd/yyyy)
12. Send one copy of your report to:	13. Name and address of insurance carrier or self-insured
U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs	employer to whom bill and copy of report are to be sent name: line 1: line 2: city: 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	n's Report of	Injury and	d Treatment	t					<	
Instructions To Physician: 1 District Director (see Item 1 regularly on form LS-204 an Your Social Security Number	2 for address ıd/or in narra	i), and a co tive form v	opy to the c while the en	ompany l	isted In Ite In your ca	m 13. Sul are. Pleas	bsequent rep	orts should b	e made	
14. What history of injury or						7				
	Chine (Colorum), p. q. p.	denne et di mai us a museum aled Delemente en escendi	mile nefembourn ühnen voi koolivoogishousi inkas kookus kuusia	maan mii kan rann sama paramana ni niga	er (1,1994) er i 164 febrúar (1,644) er i 1644 (1,644) er i 1644 (1,644) er i 1644 (1,644) er i 1644 (1,644) e	a gybony-amin'ny ad governmentahahany pemakana	gigga kiy giggan), magamar Linad Ujan ay ay inimbanti	and proughten and all agency in a special consequence of the same performance in given have	antigent times and green out of the distinction of	
15. Is there any history or e	vidence of pr	e-existing	injury, dise	ease, or pl	nysical im	pairment		annets tital and françois en promote and an dominative different mark	e transition annual transition and annual before transition transition and the	
No Yes - Please		til mantet er stil at er meller en antet till generative træke		orner recommende tennemente espesión and a comme temposyne		e de la composition della comp	en geging ag hind free tig facult for day of him define a fire of him model. As an	akkin tuunin kiri turin kan sa man maja tadun an printi turin a kiri	plane and published and Milliand Strange and an adversary and a section of the control	
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16. What are your findings (include resul	ts of x-rav	s. laborato	rv tests. e	tc.)?	17. What	is your diag	nosis?	eren kon laski konon erenkerisake asikeren lan nin tisa anosa asikala til	
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						HETTY WORK TO THE				
18. Do you believe the cond answer if there is doubt.) Yes No	ition found w	as cause	d or aggrava	ated by th	e employr	nent activ	ity describe	d? (Please ex	olain your	
19a. Did injury require hosp	italization?	No	Yes - Comp	olete b, c,	d	20. Is ad	ditional hos	oitalization rec	uired?	
b. Name of hospital c. Date admitted (mm/dd/yy	^^/		<u>' </u>		*		Yes	□No		
d. Date discharged										
21. Surgery (If any, describe	type)	and was talked the same of the state of the		maland in the first section of the same the section is a section of the section of	Malifernation of a continuous state of the continuous	22. Date	surgery perf	ormed (mm/do	i/yyyy)	
23. What type of treatment d	id you provio	le other th	an hospital	lization or	surgery?	24. What	permanent e	effects of the i	njury, if any,	
					· · · · · · · · · · · · · · · · · · ·	do vou a	nticipate?	endamatohinkana nerveh randa nerkenya titaka mitamoreke r	en anne de la mandale de l'anne manural de la l'éche de red autre de medit de l'	
$\label{eq:controlled} Z_{i,j,k,k,k} = \{ (i,j,k) \in \mathcal{A}_{i,j,k} \in$					1000	Landquora et la		Name of the second seco		
25. Date of first examination (mm/dd/yyyy) 26. Date(s) of treatment (mm/dd/yyyy)				id/yyyy)	27. Date of discharge from treatment (mm/dd/yyyy)					
28. Period of disability (if ter	mination date u	nknown ec	indicate)		nutriCostino and Sameria; or tearprise op	20 Date	employee ah	ole to resume	work	
	\$ 10 to 10 t	**************************************	er/y granical tradesium		7			(mm/dd/yyy	y) 	
Total disability:	From Storeston		To			To light work				
Partial disability:	From		То	orestonias titisminin minimo naciono con consistente.	and the same	To regular work				
30. If employee is able to res	sume work, h	as he/she	been advis	sed?	Vo Ye	s - Furnis	h date advised	(mm/dd/yyyy)		
31. If employee is able to resperformed with these limitat	sume only lig	ht work, i	ndicate phy	sical limit	tations and	d the type	of work wh	ich can reasor	nably be	
	H Bibbered And I п'явлен с ком и том основной (поской честов основной основной поской основной основной основно	тителерияння и и покуще мощем образован для стаду	**************************************			ioristocide i Harristocide di la melitrocide di casal Hill Afficia d'arrisa.	and the challes the contraction of the first one of the contraction of	e Plant bladt Lidere when the Grant were not because versure transference and Maderma is the fine	kerilikal (14 ferralimentapiaakan tarias (1771 kitau) tari lah origi erimeter eterm	
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32. Remarks and recommen	idation for fu	ture care.	if indicated			ki dila ili dila masanili sambaha vilimbasi		de bestandern de des vers û carreren rell'e Derbeste de drei de terrer e per et	destinant delta delta desembliche este de salvelle de la servicio e consequent e con la	
		,					2006			
33. Do you specialize?	lo Yes-	State spec	cialty							
34. Signature and typed name o	f physician	35. Add	dress	espena for mental mentional property and considerate	and harden have entered to planta by the entered of the entered at		36. Physicia	ın's social secui	ity number	
		line1:	with with the state of the stat	all is considered and the polypological	Lindalitina piraketa karilari (1,5 ett.) eritari	do biologica proportiva y trostopy entropa (n		And a second	The state of the s	
First Name M.I. Last N	lame	city:		бонотичКостралеция менето вышен 	cour	ntrv:	37. Date of t	his report (mm/	dd/yyyy)	
political control de la contro	MINE HISTORY WE HAVE A PROPERTY BECOMES AND	st:	zip:		Tailorit tinis britanni sini				more distribution of the second	
38. Medical bill (Charges for you	ur services ma	y be preser	nted in the sp	pace below	or on your	billhead st	tationery.)			
Date or period of treatment Services and supplies must be itemized				Qty.	Qty. Unit price		Amount			
of treatment		VIIIAMICIS AARAS OODON KASSEEGO	was tree various and an annount rations			No.	Cost	Per	g/m-1-10-10	
	ned many extracts and many analytic transfer and the second secon		en en de la company de la constantión en de la defendade de la constantión en de la defendade de la constantión							

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								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. OMB No. 1215-0160 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. FOR OFFICE USE If a question is not applicable, enter "NA". The exact point of amputation or other permanent partial impairment OWCP No. 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 Carrier's No. is needed for any answer. 1. Type of report (Mark X one) 2. Date of Injury (mm/dd/yyyy) Progress Final 3. Name of injured employee 4. Employee's home address First Name line 1: city: line 2 zip: st: 5. Name of employer 6. Name of insurance carrier 7a. Have you filed a previous report giving history? No - Answer 7b and 7c Yes - Skip to item 8 7b. State how injury occurred and give source of information. (If 7c. Was employee previously under the care of another physician for claim is for occupational disease, include occupational this injury? history and date of onset of related symptoms) 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, 9b. If employee was hospitalized since last report, indicate and give objective findings, and any changes of condition since last name and address of hospital. report.)

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.

name: line 1: line 2:

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zip:

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10e. Are you continuing treatment? 10f. If treatment			nt is continuing estimate duration (mm/dd/yyyy)	The Automorphism of the Control of t		
Yes	No	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	pol-serting transfer decision of the control of the	un in Additionary		
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4. If employee is u	inable to do his/her regul	ar work, but can do lim	ited work, specify work limit	ations due to this in	iury	
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II	V					
6. Is rehabilitation recommended?	treatment or services or Yes - Explain	evaluation No - Explain	17. If rehabilitation trea		r evaluation is To whom	recommended, No - Explain
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0. Name of attendi	ng physician (Type or pr	nt)	21. Signature of physici	an		
2. Address			23. Telephone No. (Area	a Code)	24. Date of I	•
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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 promp	tly with the District Dire	ctor in every case in v	which (1)	OMB No. 1215-0031	
Form LS-202 does not show date injured	injured	For Office Use			
employee has returned to work and later	becomes disabled for v	vork (33 U.S.C.930(b).	If the	1. OWCP No.	
employee was disabled for work more the on Forms LS-206 and LS-208. Medical re	an 3 days, compensation	n payments should be	reported	Transfer dense from the consideration from the construction of t	
following first treatment and thereafter v				Participation Assessment and Historical Resource and Assessment and Assessment and Assessment and Assessment and Assessment and Assessment Asse	
information. (if additional space is neede				2. Carrier's No.	
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information unless it displays a currently	valid OMB control numl	ber.		Application of the Control of the Co	
3. Name of injured employee (First, middle init		4	. Date of accide	ent (Month, day, year)	
First Name M.I. Last Na		en Socialisto Di Anthroparella na			
The state of the s				American de montrese, es vicinas consumentos consument	
5. Address of injured employee (Number and S) 6. Name and address	of your insurar	ice carrier	
line 1:	country	A Line is your distriction of providence of the contract of th	AND THE PROPERTY OF THE PROPER		
line 2:	en Eligne de La Castilla (Castilla Castilla Cast			city:	
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7 Initial Davied of Dischiller (Use Included	Data - E			And the state of t	
7. Initial Period of Disability (Use Inclusive a. From (Month, day, year)			- Date	and the seconds (Marsell)	
a. I rom (month, day, year)	b. To (Month, day, ye	tar)	c. Date return	ed to work (Month, day, year)	
	and a transmission of the second second difference of the second	•			
8. If this report covers a period of disability after a. and b.	l er the date shown in item 70	c. state each subsequen	t period of disa	ability. Use inclusive dates for	
a. From (Month, day, year)	b. To (Mor	nth, day, year)	c. Date returned to work (Month, day, year)		
for the second control of the second control	g= 4004-002-000-000-000-000-000-000-000-000	Station Local Halife State of Section Recognition		**************************************	
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9. Did employee receive medical attention?					
a. Yes - Give dates, names and address treatment.	es of doctors and hospitals	providing	b. No - E	Explain	
	.				
10. Was employee treated by his or her choice	of physician?	11. Was form LS-1 giv	en to employee	e when injury was reported to you?	
Yes No	Yes	☐ No			
12. Name of employer (Firm Name)		13. Employer's addres	s (Number and	Street, City, State, ZIP code)	
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				country:	
14. Signature of person authorized to sign	15. Name and official tills	of person signing		16. Date of report	
for employer	name:			(Month, day, year)	
ı	# # # # # # # # # # # # # # # # # # #			06/24/2008	
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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