Pre-Hearing Statement

Longshore and Harbor Workers' Compensation

Print | Reset | Submit

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

This form is mandatory and is required by regulation (20 CFR 702.317). Failure to return this form at the required time can cause delay in preparation of the case for formal hearing. The form will be used by OWCP to refer the claim for a formal hearing. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0085
Expire: 03/31/2011

1. Employee's name (Last, first, middle)
   Last Name* | First Name * | M.I.

OWCP No. *

Carrier No.

2. Name, address and phone number of party on whose behalf this form is submitted:
   * name:
   * line 1: | city:
   line 2: | st: | zip:
   Telephone No. | ctry:

3. Name, address and phone number of party's representative:
   * name:
   * line 1: | city:
   line 2: | st: | zip:
   Telephone No. | ctry:

4. Briefly state the facts of the claim:

5. State the issues on which the parties have reached agreement:

6. State the issues you will present for resolution at formal hearing: *

7. List the names of witnesses who will testify in person on your behalf at formal hearing. Also list reports that are to be submitted in lieu of live testimony:

8. List all exhibits, other than reports listed in item 7 above, you intend to submit at the formal hearing. (Use separate sheet or sheets if necessary). If you want the district director to send the exhibits to the Office of Administrative Law Judges, you must submit them with this form:

9. Estimate total hours needed for your witnesses to testify:

10. If an interpreter is required, state language:

11. Indicate the city of your preference for formal hearing: *

Note: Any other matters pertinent to scheduling should be explained on a separate sheet attached to this form.

12. Type or print name of person completing form: *

13. Signature of person completing form: *
   Signature

14. Date (Mo., day, year):
   05/15/2008

Public Burden Statement

We estimate that it will take an average of 10 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 Division of Longshore and Harbor Workers' Compensation, U.S. Department of Labor, Room C4315, 200 Constitution Avenue N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE.