Notice of Final Payment or Suspension of Compensation Payments

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U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

INSTRUCTIONS: This notice must be filed in triplicate with the District Director of the OWCP within 16 days after compensation has been stopped or suspended. (33 U.S.C. 914(g). If **payments have stopped temporarily, or are being modified, and will be reinstated, or payments are being continued, indicate in item 11, and give reasons. This form is to be used for reporting either disability or death benefit payments. The information will be used to verify compensation paid under the Act. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.**

OMB No.: 1215-0024

1. OWCP No.

2. Carrier's No.

3. Name and address of Employee or other beneficiary (Type or print)

Place within brackets

* Last Name | * First Name | M.I.

* line 1: | city: | country

line 2: | st: | zip:

a. OFFICE OF THE DISTRICT DIRECTOR
U.S. DEPT. OF LABOR-OWCP

CARRIER - Send copies 1, 4 and 5 to the District Director, who will forward employee's copy.

4. Name of employer *

5. Address of employer

6. Date of Injury *

7. Date employee first lost pay because of injury

8. Date physician found employee able to return to work

9. Date employee returned to work

10. Was compensation paid at the maximum rate? * ☐ Yes ☐ No

Average weekly wage $ _____ * multiplied by 2/3 = Compensation rate $ _____ *

11. State reason or reasons for termination or suspension of payments *

12. Date last payment made

13. Date of this notice * 09/22/2008

14. **ENTER ALL DISABILITY PAYMENTS**

TYPE OF DISABILITY a	FROM (Mo., day, yr.) b	TO (Mo., day, yr. incl.) c	AMOUNT PAID PER WEEK d	NUMBER OF WEEKS PAID e	TOTAL f
Temporary total					
Temporary partial					
Temporary partial*					
Permanent partial (Non-schedule)					
Permanent total					
Permanent partial (Schedule loss, facial or other disfigurement)	**Percent**	**Part of body**			
***Report on this line payment for different period or rate than payments reported in previous line.**				**TOTAL** →	

15. **ENTER ALL PAYMENTS MADE ON ACCOUNT OF DEATH**

a. NAMES OF DEPENDENTS	b. AMOUNT	c. OTHER EXPENSES	d. AMOUNT
		Funeral expense	
		No dependents-paid to treasurer, U.S. [Sec. 44(C)(1)]	
(Attach continuation sheet)		**TOTAL** (cols. b + d) →	

16. **ENTER OTHER PAYMENTS**

a. Attorney fees		c. Interest	
b. Penalty for late payment		**TOTAL** (cols. a, b, c) →	

17. Name of insurance carrier or self-insured employer *

a. Address of insurance carrier

18. Signature of person authorized to sign for carrier

Signature

19. Name and Title of person whose signature appears in item 18 *

EMPLOYEE - PLEASE READ CAREFULLY

Any claim for compensation, to be valid, must be filed IN WRITING with the District Director, OWCP, WITHIN ONE YEAR after the date of injury or date of last payment of compensation. ●If you have serious disfigurement of the face, head, or neck or other normally exposed areas which may handicap you in securing or maintaining employment, or any impairment of the body or other disability from the injury for which you have not received compensation, you should inform the District Director. (Address in 3a above)

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**

1 - District Director
2 - Employer
3 - Insurance Carrier
4 - Employee
5 - Employee's Representative