U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

OWCP File No:
Claimant:
Injury Date:
Social Security Number:

OMB No. 1215-0112
Expires: 07/31/2006

You are receiving compensation payments at the tentative rate of $ per week under the

The insurance company in this case reports they are paying you at this rate because they have been unable to obtain data as to your earnings for the year preceding your injury through their usual channels and have not been able to establish the exact amount of your earnings during that period. Under the compensation act payments are made for temporary total disability and certain other types of disability at the rate of two-thirds the employee's average weekly wage during the year preceding injury, subject to the provision that the weekly compensation rate cannot exceed $. To receive the maximum compensation rate in effect at the time of your injury, an employee must have earned an average of $ or more per week during the preceding year.

So that we may determine your correct compensation rate, it is requested that you submit a record of your earnings from all types of employment for the period to inclusive. Please use the back of this form for this purpose.

Return the completed form to this office as soon as you can.

Sincerely,

Enclosure

PRIVACY ACT OF 1974 NOTICE

In accordance with the Privacy Act of 1974, as amended, 5 U.S.C. 522a), you are hereby notified that: (1) The Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for the amount of benefits under the LHWCA. (3) Information may be given to 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. (4) Information may be given to the 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. (5) Information may be given to 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. (6) Information may be given to 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. (7) Disclosure of the claimant's Social Security Number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or other information maintained by the Office may be used for identification, and other purposes authorized by law. (8) 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.

Note: The notice applies to all forms requesting information that you might receive from the Office in connection with the processing and/or adjudication of the claim you filed under the LHWCA and related statutes.

This form letter is used to request earnings information. The information will be used to determine the correct compensation rate. Submission of the report is required to obtain payment at the correct rate (33 USC 910). Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OWCP File No: _____
Claimant: _____

Note: Earnings for several months may be grouped if desired.

20___	Name of Employer	Occupation	Amount Earned
Jan			
Feb			
Mar			
Apr			
May			
Jun			
Jul			
Aug			
Sep			
Oct			
Nov			
Dec			
20____			
Jan			
Feb			
Mar			
Apr			
May			
Jun			
Jul			
Aug			
Sep			
Oct			
Nov			
Dec			

_____
Signature

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 this burden estimate 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 C-4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.