Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act

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

Note: Please provide as much information as possible. Do not write in the shaded areas.

OMB No. 1215-0197
Expiration Date:08/31/2010

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Employee's Information (Print clearly)

1. Employee's Name (Last, First, Middle Initial)	2. Former Name (e.g. Maiden/Legal Change)	3. Social Security Number (If known)

Contact Information for Person Completing this Form (Print clearly)

4. Name (Last, First, Middle Initial)	5. Claim Type (check one)
	☐ Employee ☐ Survivor
6. Address (Street, Apt. #, P.O. Box)	7. Telephone Number(s)
	a. Home: ( ) -
(City, State, ZIP Code)	b. Other: ( ) -

Employee's Work History (Provide as much information as known - if necessary attach a separate sheet)

In chronological order, *starting with the most recent period of employment*, provide the complete work history of the employee named above. Provide as much identifying information as known concerning the name of the employer and location (city & state) where the employee performed the work. If you require additional space to explain or clarify a point, attach a signed supplemental statement to this form.

Employer - 1

Start Date: Month / Day / Year

End Date: Month / Day / Year

Work Schedule (check one)
☐ Full-time
☐ Part-time

Facility Name (spell out name)

Specific Location (building/site/mine/mill)

City/State where worked performed

Contractor/sub-contractor or Vendor name(s)

Type of Facility/Employer (check one)
☐ - Department of Energy Facility
☐ - Atomic Weapons Facility
☐ - Beryllium Vendor
☐ - Uranium Miner/Miller/Transporter
☐ - Unknown

Position Title or Mine/Mill Activity

Was a dosimetry badge worn while employed? ☐ YES ☐ NO ☐ Unknown

Work Identification Number

If known, provide the Dosimetry Badge Number:

Description of Work Duties (Describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility

Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)

☐ Former Worker Program (FWP)
☐ Radiation Exposure Screening and Education Program (RESEP)
☐ Other Medical Study
☐ Other Medical Surveillance Program
☐ Union Member
☐ Other (specify):

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Employer - 2

Start Date: Month Day Year

End Date: Month Day Year

Work Schedule (check one)
- Full-time
- Part-time

Facility Name (spell out name)

Specific Location (building/site/mine/mill)

City/State where worked performed

Contractor/sub-contractor or Vendor name(s)

Type of Facility/Employer (check one)
- Department of Energy Facility
- Atomic Weapons Facility
- Beryllium Vendor
- Uranium Miner/Miller/Transporter
- Unknown

Position Title or Mine/Mill Activity

Was a dosimetry badge worn while employed? YES NO Unknown

Work Identification Number

If known, provide the Dosimetry Badge Number:

Description of Work Duties (Describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility

Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)
- Former Worker Program (FWP)
- Radiation Exposure Screening and Education Program (RESEP)
- Other Medical Study
- Other Medical Surveillance Program
- Union Member
- Other (specify):

Employer - 3

Start Date: Month Day Year

End Date: Month Day Year

Work Schedule (check one)
- Full-time
- Part-time

Facility Name (spell out name)

Specific Location (building/site/mine/mill)

City/State where worked performed

Contractor/sub-contractor or Vendor name(s)

Type of Facility/Employer (check one)
- Department of Energy Facility
- Atomic Weapons Facility
- Beryllium Vendor
- Uranium Miner/Miller/Transporter
- Unknown

Position Title or Mine/Mill Activity

Was a dosimetry badge worn while employed? YES NO Unknown

Work Identification Number

If known, provide the Dosimetry Badge Number:

Description of Work Duties (Describe in detail)

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es) at this facility

Indicate whether the employee participated in any employer health programs or unions at this facility (check all that apply)
- Former Worker Program (FWP)
- Radiation Exposure Screening and Education Program (RESEP)
- Other Medical Study
- Other Medical Surveillance Program
- Union Member
- Other (specify):

Declaration of the Person Completing this Form

Any person who knowingly makes any false statement, misrepresentation, concealment of fact of any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I affirm that the information provided on this form is accurate and true. I also authorize the Department of Justice, Social Security Administration, any Former Worker Program, union, medical study or medical surveillance program (or any other person, institution, corporation, or government agency) identified on this form to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.

(Signature) (Date)

Resource Center Date Stamp

Instructions for Completing Form EE-3

This form is used to gather information regarding an employee's work history for a claim filed under the Energy Employees Occupational Illness Compensation Program Act. List all periods of employment and provide as much information as known for each period of employment. If you require additional space, attach a supplemental statement to this form. You may use as many copies of Form EE-3 as necessary in order to provide a complete employment history for the employee.

Dates of Employment

Beginning with the most recent period of employment and working backward, list the period of employment for each job held.

Work Schedule

Indicate whether the employee worked full-time or part-time at the listed facility.

Facility Name

Identify the name of the facility the employee worked at for the listed period. Spell out any initials used to describe the facility.

Specific Location

Provide any useful descriptive information about where the work was performed at the listed facility. Spell out any initials used to describe the location.

City/State where worked performed

Indicate the city and state where the listed facility was located.

Contractor/sub-contractor or Vendor name

Provide the name of the specific employer the employee worked for at the listed facility. Spell out any initials used to describe the employer.

Type of Facility

Check the box that identifies the type of facility that best describes the employee's work situation.

Position Title

Identify the employee's position title or Mine/Mill activity (Miner, Miller, or Ore Transporter)

Dosimetry Badge

Indicate whether or not a dosimetry badge was worn while employed at the listed facility. If known, provide the badge identification number.

Work Identification Number

If known, provide the work identification number for the listed period of employment.

Description of Work Duties

Provide a brief, but detailed, description of the work activities performed during the listed period of employment.

Describe or list the work conditions/exposures you believe caused or contributed to the claimed work illness(es)

Provide a brief, but detailed, description of the factors believed to have caused or contributed to the claimed illness(es) at the listed facility.

Indicate whether the employee participated in any employer health programs or unions

Check the box or boxes indicating whether the employee participated in any employer health programs or unions at the listed facility.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 *et seq.*) (EEOICPA) 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 received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the employee at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average one (1) hour per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Completed claims are to be submitted to the appropriate district office of the Office of Workers' Compensation Programs. Persons are not required to respond to the information collections on this form unless it displays a currently valid OMB number.

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