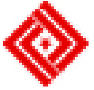
Report of Earnings

Longshore and Harbor Workers' Compensation Act, or Extension

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



Instructions to Employee: You are required to complete and sign this form and return it to the employer/insurance carrier/ special fund listed in item 4 within 30 days after receipt even if you have no earnings to report. (20 CFR 702.286) See page 2 for definition of "Earnings" and additional instructions. Loss of compensation benefits may result if this form is not completed and filed in accordance with instructions.

OMB No.: 1215-0160

Instructions to Employer / Insurance Carrier: Complete items 1 through 6.

1. **Place within brackets**

Last Name First Name M.I.

name:

line 1: city:

line 2: st: zip:

country:

Name and Address of Employee (Type or print)

2. OWCP No.

3. Carrier's No.

4. Name of Employer/Insurance Carrier/Special Fund

5. Address of Employer/Insurance Carrier/Special Fund

line 1: city:

line 2: st: zip:

6. Period For Which Earnings From Employment or Self-Employment Must be Reported

From **To**

7. Have You Had Any Earnings From Employment or Self-Employment During the Period Shown in item 6? (See page 2 for definition of "Earnings")

Yes **No**

8. Complete the Following if You Had Earnings From Employment During the Period Shown In Item 6.

Name and Address of Employer	Periods of Employment		Amount Earned
	From	To	
Name city: st: zip:			
Name city: st: zip:			
Name city: st: zip:			
Name city: st: zip:			

9. Complete the Following If You Had Earnings From Self-Employment During The Period Shown In Item 6.

Type of Business or Service	Dates Performed		Gross Revenue Received	Profits or Net Earnings Received
	From	To		

10. I certify that the above information I have provided is true, complete and correct to the best of my knowledge and belief.

Signature and Print Name **Date**

IMPORTANT NOTICE

Section 31(a)(1) of the Longshore 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 both.

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INSTRUCTIONS TO EMPLOYEE

You are required to report on this form all earnings from employment or self-employment earned during the period specified on page 1 of this form (20 CFR 702.286). An employee who fails to report his/her earnings when requested or knowingly and willfully omits or understates any part of such earnings may forfeit his/her right to compensation with respect to any period during which this report is required. Compensation forfeited, if already paid, shall be deducted from any future compensation which may be due in accordance with a schedule determined by the District Director of the Office of Workers' Compensation Programs having jurisdiction in the case. (33 U.S.C. 908(j).

Earnings are defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment even if the business or enterprise operated at a loss or if the profits were reinvested.

An employer, insurance carrier, or the Director of the Office of Workers' Compensation Programs (for those cases being paid from the Special Fund) may require an employee to file this report semiannually. The information provided will be used to determine entitlement to benefits. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

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 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**