Employment History

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

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Note: Persons are not required to respond to this collection of information unless it displays currently valid OMB control number.

OMB No. 1240-0038
Expires: 10/31/2014

Please complete as accurately as possible the miner's complete employment history. (Where employment was in coal mining, specify whether the mine was a strip mine or an underground mine.) This report is authorized by law (30 U.S.C. 901 et. seq.) and required to obtain a benefit. While you are not required to respond, your cooperation is needed to ensure that full and proper consideration is given to this claim. Disclosure of the social security number is voluntary. Failure to disclose such number will not result in the denial of any right, privilege or benefit to which you may be entitled.

Miner's Name
First Name | M.I. | Last Name

Miner's Social Security Number

1. Name and Address of Employer (City and State)	2. Type of Industry (Indicate if coal mining, extraction or preparation of coal, coal mine construction, or transportation in or around a coal mine, steel, manufacturing or other)	3. Occupation (Specify type of work)	4. Period of Employment Mo/Yr	Mo/Yr	5. Exposure to dust, gases, or fumes? (Yes/No)
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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					Yes No
					Yes No
					Yes No
					Yes No

I hereby certify that the Information given by me on and In connection with this form Is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $1,000, or by Imprisonment for not more than one year or both.

6. Signature of Claimant (First, middle, last)	7. Date (Month, date, year)

8. Mailing Address (Number, Street, Apt. No., P.O. Box or Rural Route)	9. City and State

10. ZIP Code	11. County where you live	12. Telephone number (include area code)

Witnesses are required only if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full address.

Signature of Witness	Signature of Witness
Address (Number, Street, City, State & ZIP Code)	Address (Number, Street, City, State & ZIP Code)
city: state: zip:	city: state: zip:

PRIVACY ACT STATEMENT

The following statement is made in accordance with the Privacy Act of 1974, as amended (5 U.S.C 552a). (1) Submission of this report is required under the Black Lung Benefits Act. (2) The information in the report will be used to determine eligibility under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant or beneficiary, or have complied with the provisions of 20 CFR Part 725. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of your social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 40 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room N-3464, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE