



Workers' Compensation



ALL YOU NEED TO KNOW ABOUT WORKERS' COMPENSATION PROGRAM

Last Updated September 30, 2016

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WORKERS' COMPENSATION GUIDELINES

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WORKERS' COMPENSATION PROGRAM OPERATION

Overview

In this time of cost concern, Non-Appropriated Fund Instrumentality (NAFI)(s) shall make every effort to control workers' compensation cost. This can only be effective if it starts at the top and is communicated down the chain of command. In order to do this, the head of the NAFI shall:

- Designate an activity coordinator to monitor and administer the workers' compensation program.
- Establish and operate an effective and proactive safety program that identifies and corrects hazards to prevent accidents, investigates accidents and offers safety training and education.
- Establish and maintain a positive management attitude toward safety, accident prevention and disability management. This will result in:
 - Shortened disability times and reduced workers' compensation costs through a Return-to-Work program.
 - Employees who are productive while they are recovering from job related injuries.
 - An enhanced ability to achieve quality and production goals.
 - Employees who feel positive about themselves and their ability to contribute to their department.
- Establish and operate an effective orientation and training program for employees and supervisors concerning workers' compensation.
- The activity should additionally provide regular and recurring workers' compensation and safety training.

PROGRAM INFORMATION

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT (NAFIA).

The NAFIA effective 18 November 1958 (now 5 USC 8171-8173), extended the provisions of the Longshore and Harbor Workers' Compensation Act (LHWCA) (33 USC 901 et seq.) to Non-Appropriated Fund (NAF) employees.

WHO IS COVERED/NOT COVERED BY THIS PROGRAM

Provisions of the LHWCA apply to benefits for disability or death resulting from a job-related injury or occupational disease to:

- Employees of NAFIs within the U.S.
- Citizens or permanent residents of the U.S. or a territory, employed by NAFIs outside the U.S.
- Active Duty military members, including those employed during their off-duty hours, are NOT eligible for NAF workers' compensation. They are covered with military care.
- Contractors are not covered; they must have their own coverage.
- Foreign National employees and third party national employees overseas are not covered. This coverage must be provided for under Status-of-Forces Agreement (SOFA).

COVERAGE

- Compensation will be paid under the LHWCA for the disability or death of an employee arising out of and in the course of employment.
- Compensation may be denied if the injury or death was due solely to intoxication or resulted from a willful intent to injure or kill oneself or another person.

In broad terms, LHWCA covers employees:

1. From the time they report for duty until the time they leave at the end of their working hours.
2. While traveling away under orders of temporary duty or while traveling locally at the direction of their employer unless the employee deviates from the scope of employment.

LHWCA does not cover an employee while they are traveling to or from work.

LIABILITY

- NAFIs must compensate their employees as stated in the LHWCA.
- Compensation for employees will be provided under a self-insured Workers' Compensation Program managed at Commander Navy Installations Command (CNIC).
- A contract for claims adjudication will be procured by CNIC to manage workers' compensation claims for eligible employees.
- The third party administrator (TPA) will pay employees, as required by the LHWCA, from funds provided by CNIC.

COMPENSATION

- Compensation is not provided for the first three business days of disability. These three days are considered the waiting period.
- If the injury is disabling for more than 14 days, there is no waiting period.

BENEFITS AUTHORIZED

Medical Care

- NAF employees eligible for benefits are entitled to medical services, medicines and supplies, subject to the provisions of the LHWCA.
- Under the LHWCA, an employee has the right to choose an attending physician to provide medical care relating to their injury.
- An employee **may not** change physicians after the initial choice unless prior consent has been approved for the change by the TPA.
 1. When prompt treatment is needed and the employee is unable to choose a physician, the NAFI will select one.
 2. The treating physician will, within 10 days after treatment, send a copy of the Request for Examination and Treatment (Form LS-1) to the Deputy Commissioner of the local Department of Labor (DOL), the TPA, and the employer. The physician will also send the Attending Physician's Supplementary Report (Form LS-204).

Disability

- Total: Employees permanently or temporarily totally disabled because of an on-the-job injury or occupational disease may receive 66 2/3 percent of their Average Weekly Wage (AWW).
 - The minimum and maximum weekly compensation rates change annually and are published by the DOL each year.
- Partial: Compensation for permanent or temporary partial disability is 2/3% of the difference between AWW before injury and the wage-earning capacity after the injury.
 - Employees who sustain a permanent impairment or amputation to certain parts of the body (fingers, toes, hands, feet, arms, legs, hearing loss and eyes) may also be entitled to scheduled awards.
- Death Benefits: Death benefits are payable to eligible survivors if the injury or disease causes death. Compensation includes reasonable funeral expenses up to \$3,000. A widow/widower can receive compensation at the rate of 50 % of the AWW of the deceased. Should the surviving widow/widower remarry, they are entitled to a two-year lump sum payment at 50% of the AWW.

Death benefits for a surviving child shall be paid at 16 2/3 % of the AWW if there is a surviving widow/widower. If there is one surviving child of the deceased employee, the child shall have his/her compensation increased to 50% of wages, and if there is more than one surviving child of the deceased employee, the children will receive, in equal parts, 50% of the wages increased by 16 2/3% of wages for each child in excess of one: provided, that the total amount payable shall in no case exceed 66 2/3 % of

the wages. If there is more than one dependent, each would split equally the 16 2/3rds.

These benefits would be paid until the dependent reaches the age of 18 (unless they are still attending high school and would then end at the end of the school year). Benefits would continue beyond that if the dependent were a full time student at an accredited university up to age 23.

FEES TO ATTORNEYS

- All notice of representation must be sent to the DOL. The Secretary of Labor will not approve payment of a fee to a claimant's representative who has been disqualified from representing claimants under the LHWCA.

POSTING NOTICE OF COVERAGE

- Each NAFI will post a Notice to Employee, DOL Form LS-242 (NF)) in a place where it can be seen easily. This form is provided annually by CNIC. This form also states that CNIC NAF has workers' compensation coverage under the LHWCA. (A sample of this notice can be found in the "Forms" section.)

USE OF MILITARY MEDICAL FACILITIES

- Use of military medical facilities by NAFI employees is limited to **emergency treatment only**.
- In non-emergency cases and for all other treatment, employees must select their own civilian physician and medical facility.
- In **overseas areas** or in **remote areas** of the U.S. where there are **no** adequate civilian medical facilities for NAFI employees, follow up treatments or hospitalization in military medical facilities are authorized.

LEAVE STATUS

Leave Without Pay

- Leave without pay (LWOP) shall be granted to an employee who is covered by workers' compensation.
- Administrative leave will be granted for the initial first aid treatment on the day of injury.
- LWOP will start on the first full day of disability.
- An employee may remain in an LWOP status for up to one year while receiving workers' compensation benefits.
- After one consecutive year in an LWOP status, the employee may be terminated without cause. The termination does not affect the employee's entitlement to benefits under the LHWCA.

MISREPRESENTATION

- The LHWCA includes the following categories of misrepresentation as well as the penalties applicable:
 1. Claimant – A claimant who knowingly and willfully makes a false statement or misrepresentation for the purpose of obtaining benefits or payment under the LHWCA will be guilty of a felony and upon conviction will be punished by either a **fine not to exceed \$11,000.00**, or by **imprisonment not to exceed 5 years**, or in some cases **both** may be applicable.
 2. Claimant’s Attorney or Other Representative – A claimant’s attorney or other representative who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under the LHWCA will be guilty of a felony and upon conviction will be punished by either a **fine not to exceed \$10,000.00** or by **imprisonment not to exceed 5 years**, or in some cases **both** may be applicable.
 3. Employer, His Agent or Employee of Insurance Carrier – The employer, his agent, or an employee of an insurance carrier who knowingly and willfully makes a false statement or representation for the purpose of reducing, denying, or terminating benefits to an injured employee, or his dependents when the injury results in death, will be punished by either a **fine not to exceed \$10,000.00** or by **imprisonment not to exceed 5 years**, or in some cases **both** may be applicable.

PENALTIES AND FINES

- Three different penalties and fines may be assessed against the NAFI for failure to file timely reports or pay compensation on time:
 - **10% Penalty** – TPA assessed for failure to pay compensation on time. Compensation must be paid within **14 business days after it becomes due** or the penalty is assessed on the unpaid monies. Although seldom done, the DOL may excuse late payment when compelling reasons are shown for the delay. This expense is paid to the employee by the TPA; **however, it is not a covered expense under the Workers’ Compensation Program and the cost will be passed back to the employing NAFI.**
 - **Interest Penalty** – TPA is assessed interest on all monies due. Interest will be calculated on the basis of a rate determined by the Secretary of the Treasury and published by the DOL. This expense is paid to the employee by the TPA; **however, it is not a covered expense under the Workers’ Compensation Program and the cost will be passed back to the employing NAFI.**

- **\$22,587.00 Fine** – CNIC/TPA may be assessed a fine not to exceed \$22,587 for knowingly and willfully failing or refusing to file a form Employer's First Report of Injury (LS-202) within 10 days business from the date of injury, or from the date the employer had knowledge of the injury or death.

WHO IS CNIC'S WORKERS' COMPENSATION CARRIER

CNIC has selected Contract Claims Services, Inc. (CCSI) as the Third Party Administrator (TPA) for our workers' compensation program. CCSI's general contact information is:

P.O. Box 541388
Dallas, TX 75354
800.743.2231 **Phone**
972.786.7349 **Fax**

FILING A CLAIM

Timely and effective claim processing is a necessity should an injury occur. The method by which a claim is handled can affect the progress and resolution of a disability case as well as the severity of dollar loss. Well-established and timely claim procedures are of prime importance.

Supervisor Responsibilities

Once the employee has reported the injury/illness to their supervisor, the LS-202 paper form must be completed by the supervisor and a brief explanation of how the workers' compensation works should be explained to the employee (a thorough explanation of the program is given in orientation). Other forms, such as the LS-1, Choice of Physician Statement, the Temporary Prescription Services form, and the Employee Consent & Authorization form will be given to the employee by the supervisor if applicable. An explanation for these forms can be found in later sections of this guide. At this time, the "What Happens Next" form can also be given to the employee.

All forms must be submitted to the workers' compensation Point of Contact (POC) the same day of injury to ensure the claim is filed within three business days of the injury. A Supervisor's Checklist can be found in the forms section as a guide for the supervisor.

In the event the employee needs immediate attention, this process of completing forms can be completed after medical care is given to the employee.

Workers' Compensation POC Responsibilities

Once the supervisor has submitted the paper LS-202 and all applicable forms for the injured employee, the POC must file the claim with our TPA. The claims are filed on the CCSI website:

<https://www.ccsapps.com/CCSWebsite/>

(Please contact the headquarters Workers' Compensation POC to set up an account.)

Report Only

If the reported injury/illness does not require medical treatment, the incident is considered a report only. When this occurs, a LS-202 form must be filed through the CCSI website.

Note: In cases of severe injury or death, the NAF activity shall notify CNIC (N94) within 24 hours.

Report with Medical

If the reported injury/illness requires medical attention, the incident is considered a report with medical. When this occurs, a LS-202 form must be filed through the CCSI websites.

The supervisor must have the following forms completed and signed by the injured employee; which are then submitted to the Workers' Compensation POC along with the LS-202:

- **LS-1 (Request for Examination and Treatment)**
This form is completed by the supervisor and informs the initial treating physician that the injury is a possible workers' compensation injury. It also authorizes examination and/or treatment under the LHWCA. The employee should only be given the LS-1 form **the day** of injury which is also the **same day** the employee is seeking medical treatment. Please explain to the employee that the physician's office is required to send this form to the address at the bottom of the LS-1.
- **Choice of Physician Statement**
This form is completed by the employee. The employee may select any physician of their choosing. If the injury/illness is an emergency, the employee must be taken to the nearest emergency medical facility. This form is to be scanned to the TPA. Once the physician is selected by the employee, the employee may not change physicians unless the TPA has given prior consent for the change.
- **Employee's Consent and Authorization to release Medical and/or Dental Records**
This form is completed by the employee and gives authorization to have the employee medical records furnished to the employer and/or its authorized representative. This form is to be scanned and sent to the TPA.
- **Temporary Prescription Services form**
This form is to be completed by the supervisor and given to employee to expedite the processing of a workers' compensation prescription if applicable.

Return to Work Statement

Once the employee returns from the treating physician, the employee will be given a return to work statement. This statement will return the employee to work:

- Full-duty
- With restriction's (light duty)
- Off work (for a specific amount of time)

Return to Work Full –Duty

If the employee has returned to work at full-duty, scan a copy of the statement to the TPA. If there is no follow-up, there is nothing more you must do.

Return to Work with Restriction

If the employee has returned to work with restriction(s) (light duty), the following form must be completed:

- **Modified/Alternative Work Form**

This form is completed by the supervisor and submitted to the TPA by the Workers' Compensation POC. This form is used to advise the TPA if the activity will provide light or modified duty for the injured employee. Modified or Alternative duty is always encouraged through a Modified/Alternative Work Program.

Modified/Alternative Work Program

- A Modified/Alternative Work program is intended to return an employee to work as quickly as possible without risk to the employee's health. Some change in the job may be required in returning the injured employee to work. This may involve simple changes to the physical characteristics of the original job, temporarily reassigning the employee to productive alternate duties or providing adaptive devices (such as lifting equipment) to reduce the physical demands of the job.
- The first priority should be to return the employee to the same job, if medically advisable. Building on existing work experience and working relationships avoids adding the stress of adjusting to new tasks and surroundings.
- Return the employee to accustomed, but modified work in the same department. Job or work site modifications may include a temporarily reduced work schedule, changed duties, trading heavier parts of the job with co-workers, altering the way duties are performed, physical changes in the work station and/or specialized tools or adaptive devices.
- Return the employee to work with the same employer, but in a different position. Capitalize on transferable employment skills or provide on-the-job training. In some instances, it may be necessary to reassign the employee to a different area of the activity.
- It is critical to maintain communication with the employee. Studies have shown that regular, positive, contact with supervisor rate higher with employees than many other types of incentives. The supervisor has a major influence on the attitude of the employee in this situation. Do not let the employee sit at home. Studies also show that employees that sit at home develop emotional issues. Engage them! Treat the employee better than when they were at work. If possible, take them to their doctor's appointment/therapy.
- A form letter shall be used to make a formal job offer to the employee.

Off Work

If the employee is taken off work for more than 3 business days, the following form must be completed through the CCSI website:

- **LS-210 (Employer's Supplemental Report of Accident or Occupational Illness)**

This form is used to notify the TPA and the DOL Office of Workers' Compensation Program (OWCP) that the employee has lost time due to a work related injury/illness. This form is completed on the CCSI website, must be printed, signed by the workers' compensation POC and mailed to the New York OWCP office. If forms are completed after initial filing, all other forms are to be mailed to Florida OWCP office.

When the employee is off work, as prescribed by a physician, the manager or supervisor should contact the employee within 24 hours of the occurrence of the injury to check on the employee's condition. The manager or supervisor should make weekly or biweekly calls to the employee in on-going cases for at least the first three months. These calls should be made quarterly thereafter. These calls are to see how the employee is doing and to identify further action. All communications with the employee should be documented on the "Telephone Log" form.

The supervisor should consider sending a get-well card and inviting the employee to organizations social events in long term cases.

Almost every study and publication on workers' compensation indicates that one of the most effective ways to show employees that management cares and to control cost is to have an aggressive Modified/Alternative Work program.

If the employee cannot be placed in the Modified/Alternative Work program, place them on FMLA. We do not need medical certification; we already have that information from the doctor. Please follow FMLA procedures.

Injury that Occurs on Activity Parking Lot

When an injury occurs on an activity parking lot or if there is a question as to whether the injury occurred in an activity owned and controlled space, the supervisor will complete the Parking Lot Injury Checklist, drawing/diagram of the accident and submit it to the Workers' Compensation POC along with other applicable forms.

Prescription Card

Once a claim has been filed, the employee will receive a prescription card from Express Script for the purpose of medications for their workers' compensation injury. Any other use may result in denial of prescription card.

Details to Remember

The required forms must be completed and sent to the TPA immediately upon knowledge of the occurrence of the injury. The reported injury must be inputted into the TPA website and submitted to the New York DOL office within 10 business days. Financial penalties may be incurred if report is not filed in the specified timeframe. The medical provider documents, initial/recommended treatment, reports, and recommendations are sent to the TPA.

INJURY AND ILLNESS RECORD KEEPING

Under the Occupational Safety and Health Administration (OSHA) Recordkeeping regulation (29 CFR 1904), CNIC is required to prepare and maintain records of serious occupational injuries and illnesses, using the OSHA 300 Log. This information is important for employers, workers and OSHA in evaluating the safety of a workplace, understanding industry hazard, and implementing worker protections to reduce and eliminate hazards.

The employer must post Form 300A, the Summary of Work-Related Injuries and Illnesses, in the workplace every year from February 1 to April 30 for the previous year. Current and former employees, or their representatives, have the right to access injury and illness records. Employers must give the requester a copy of the relevant record(s) by the end of the next business day.

OSHA Forms 300, 300A and 301

Forms and detailed instructions can be found in the forms section of this guide. Fillable forms can be downloaded and saved at the following link:

<https://www.osha.gov/recordkeeping/RKform300pkg-fillable-enabled.pdf>

What is a Recordable Injury and Illness?

An injury/illness must meet the general recording criteria to be recordable, if the injury/illness results in any of the following: death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness.

You must also consider a case to meet the general recording criteria if it involves a significant injury and illness diagnosed by a physician or other licensed health care professional. Even if an injury/illness does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness it is considered recordable.

LS Form Instructions

HOW TO COMPLETE FORM LS-202 -PAPER COPY Supervisor

Sections 1 - 2 Leave blank.

Section 3 Fill in date and Time of Accident.

Section 4 Fill in first, middle initial and last name and telephone number.

Section 5 Fill in employee's address.

Section 6 Mark Box B.

Section 7 This will only be filled in when marking the box Non-Appropriated Fund Instrumentalities Act.

Sections 8 – 19 Complete information accordingly

Section 20 Enter the date (mm/dd/yyyy) and time the injured employee's pay stopped. If pay did not stop, then write by the entry, "Did Not Stop" in Section 20.

Section 21 Complete which days usually worked per week.

Section 22 Enter the date the employer was first informed the illness or injury was work-related. (Section 22 does not necessarily have to match the date in Section 3. Sometimes employers are aware of employee's illness(es) or injury/injuries, but were not informed that it was work-related.)

Section 23 Fill in each subsection a,b,c, and d as applicable. However, if entering in on computer...it will only allow you to fill in one option. In that case, enter in the hourly rate.

Section 24 Complete with the address of activity or facility where accident occurred.

Section 25 Tell how the employer or supervisor became aware of the work-related injury, i.e. "employee's verbal report, employee's written notice, or by employee's agent.

Section 26 Completely describe how "the employee says" the accident happened. Tell what the employee says he/she was doing at the time of the accident, what happened, and how it happened. Name any objects or substances involved and explain how they were involved.

Section 27 Enter the type of injury, naming the part of the body affected, e.g., fractured leg, cut right thumb, or bruised left hand. If a part of the body was lost, describe fully.

Section 28 Complete.

Section 29 Enter the date (mo/day/yr) that the employer authorized medical care. Enter only when the LS-1 was completed and provided to the employee.

Section 30 Complete.

Section 31 By completing and forwarding this form to the third party administrator who has been contracted to process the workers' compensation claims, the answer should be "Yes".

Section 32 Enter the name and address of the physician who treated the employee.

Section 33 Enter the name and address of the treating facility.

Section 34 Enter the address of the current third party administrator which has been contracted to process the workers' compensation claims. Provided in the point of contact listing.

Section 35 Enter the name and full correct mailing address of the employing NAFI. (Include the activity number after the name).

Section 36 Enter "Non-Appropriated Funds," to describe type of employer's business.

Section 37 Complete

Section 38 Complete

Section 39 Complete

ADDITIONAL INFORMATION

The following information is requested to be put on all LS-202s to expedite the processing of the claim:

The employee's date of hire on the line above Section 1

A point of contact name and telephone number, if different than the supervisor, on the line above Section #2.

If the employer doubts the validity of the claim, then a written statement may be attached to the LS- 202.

The workers compensation POC must complete LS-202 on the TPA website. The paper form is optional if the workers' compensation POC is the initial contact, you may enter the information directly into the workers' compensation website.

HOW TO COMPLETE FORM LS-202 (TPA WEBSITE) Workers Compensation POC

This is a required form which is completed on the TPA website by the employer to report an injury or occupational illness when the employer becomes aware of such injury or illness and/or the injured worker loses one or more shifts of work due to the injury/illness. It is a reporting tool, not an admission of liability.

This form may be found at <https://www.ccsapps.com/CCSWebsite/>. You may obtain your log in credential from the headquarters workers' compensation representative. Complete the form, submit, and print for your records. If the employee requires medical attention and will be out more than one day (not including the day of injury), this form must be mailed or faxed to:

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
201 Varick Street, Room 740
Post Office Box 249
New York, NY 10014-0219
Fax (646)264-3002

The New York City DLHWC District Office will assign OWCP case numbers to all new cases, regardless of the location of the injury or the claimant's home address. The New York City office is thus designated as the "Central Case Create" site. Unless a case number has already been assigned, you should submit the following forms to the Central Case Create site.

Complete the following fields:

The screenshot shows a web form titled "LS202 FIRST REPORT OF INJURY OR ILLNESS". At the top, there are tabs for "LS202", "LS210", and "ADMIN". The form has a "Cancel" button in the top right corner. The fields are as follows:

- Social Security No.:** 123456789
- OWCP No.:** LEAVE BLANK
- Date and Time of Accident:** Date: 01/02/2014, Time: 07 : 30, AM selected.
- Name of Injured/Deceased Employee:** Last Name: DOE, First Name: JANE, MI: I, Phone: 901-762-3545
- Employee's Address:** Street: 456 NAVY WAY, City: MILLINGTON, State: TN, Zip: 38122

Injury is Reported Under the Following Act

- Longshore and harbor Workers' Compensation Act
- Defense Base Act
- Nonappropriated Fund Instru-Mentalities Act
- Outer Continental Shelf Lands Act

Indicated Where Injury Occurred (Longshore Act only)

- Aboard Vessel/Over Navigable Waters
- Pier/Wharf
- Dry Dock
- Marine Terminal
- Building Way
- Marine Railway
- Other Adjoining Area

*** Sex**

- F
- M

*** Date of Birth**

06/19/1954

Did Injury Cause Death?

- Yes
- No

If No, Did Injury Cause Loss of Time Beyond Day or Shift of Accident?

- Yes
- No

Date and Hour Employee First Lost Time Due to Injury

Date

Time

:

- AM
- PM

Did Employee Stop Work Immediately?

- Yes
- No

Date and Hour Employee Returned to Work

Date

Time

:

- AM
- PM

Was Employee Doing Work When Injured/Killed? (If no, explain in Item 26)

- Yes
- No

Did Injured/Death Occur on Employer's Premises?

- Yes
- No

* NAFI Code
 -- SELECT FROM LIST --

* Dept. in Which Employee Normally Works(ed)
 -- SELECT NAFI FIRST --

* Employee Job Classification
 -- SELECT FROM LIST --

* Occupation
 -- SELECT FROM LIST --

Date and Hour Pay Stopped
 Date Time : AM PM

Which Days Usually Worked Per Week?
 S M T W T F S

* Date Employer or Foreman First Knew Of Accident
 01/02/2014

Wages or Earnings (Include overtime, Allowances, etc.)
 Hourly \$
 Daily \$
 Weekly \$
 Yearly \$

Exact Place where Accident Occurred. This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.
 EMPLOYEE BREAK ROOM

How was Knowledge of Accident or Occupational Illness gained?
 EMPLOYEE REPORTED TO SUPERVISOR

* Describe in full how the accident occurred
 EMPLOYEE STATES

Nature of Injury
 -- SELECT FROM LIST --

Kind of Injury
 -- SELECT FROM LIST --

Agency of Injury
 -- SELECT FROM LIST --

Part of Body
 -- SELECT FROM LIST --

28. Has Medical Attention Been Authorized? Yes No

LS-1 issued? Yes No

Enter Date of Authorization

Was First Treating Physician Chosen By Employee?
 Yes No

Has Insurance Carrier Been Notified?
 Yes No

Physician
 IF MEDICAL TREATMENT IS REQUIRED

Address

City State Zip
 --- -

Hospital

Address

City State Zip
 --- -

33. Insurance Carrier

Address

City State Zip
 -

Employer

* Address

* City State Zip
 --- -

Nature of Employer's Business

Person Completing this Report	Official Title	Date of Report
<input type="text" value="KIMBERLY SEYMOUR"/>	<input type="text" value="HR ASSISTANT"/>	<input type="text" value="01/16/2014"/>

Special Comments to Supervisor or Adjuster

HOW TO FILL OUT FORM LS-1 Supervisor

This form is given to the injured worker by the employer/insurance carrier to authorize the injured worker to select and be treated by a physician of the injured worker's choice. This form is only released per claim and it must have the name of the authorized physician or medical facility listed. It is important not to release this form if the employee does not know where treatment will be rendered. It is a two-sided form; the employer/insurance carrier completes the first page and the selected attending physician completes the second page. **This form is *only* given to the employee the *day of initial injury*.**

This form may be found at www.dol.gov, look under the "Find it" column. Click on Form and scroll down, until you see the Form No. you are looking for. Click on it and it will bring you to the form, you may fill out the form before printing if you prefer.

[First Page]

Section 1 Check box "C" only.

Section 2 Complete the name and address of the physician treating the employee.

Sections 3 – 5 Complete.

Section 6 Completely describe how "the employee says" the accident happened. Tell what the employee says he/she was doing at the time of the accident, what happened, and how it happened. Name any objects or substances involved and explain how they were involved.

Section 7 Complete.

Section 8 To be completed by the person authorized to sign for the employer and the title of that person.

Section 9 Enter the full name and mailing address of the employing activity. (Include activity number after the name.)

Section 10 Enter the telephone number of the employing activity.

Section 11) Enter the date the Form LS-1 was signed.

Section 12 Complete with the address for the Department of Labor New York OWCP office.

Section 13 Enter the name and address of the current TPA which has been contracted to process the worker's compensation claims. Provided in the point of contact listing.

- Provide the original LS-1 to the employee to present to the treating physician or facility, so that the physician can complete the second page.
- The physician's office should mail this form directly to DOL. However, in the case where the completed form is returned to the workers' compensation POC, the form should be mailed to New York OWCP office.

Request for Examination and/or Treatment

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs



Part A - Authorization

OMB No. 1240-0029

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the **employee's choice** ("See item below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course of employment.

Mark either box A or B in item 7. The original and at least two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the District Director and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:

- A Longshore and Harbor Workers' Compensation Act
- B Defense Base Act
- C Nonappropriated Fund Instrumentalities Act
- D Outer Continental Shelf Lands Act

2. Name and address of physician or medical facility authorized to provide medical service

* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diagnose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name: Dr. Seuss
line1: 125 Stripped Hat Lane city: Woville
line2: st: TN 38056

3. Employee's Name

Nancy L Doe

4. Date of Injury (mm/dd/yyyy)

04/01/2014

5. Occupation

Auditor

6. How accident or illness occurred

Employee was walking in break room when she slipped on water that was on the floor; falling on tailbone

7. You are authorized to provide medical services to the employee as follows:

- A If you believe the condition is related to the injury, or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.
- B If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

You are requested to submit a written report of first treatment within 10 days to the District Director at the Office named in item 12 below (See back of this form for Instructions as to medical report and the submission of your charges).

8. Signature and title of authorizing official (Sign all copies)

Kimberly Seymour HR Benefits Assistant

9. Name and address of employer

name: CNIC
line1: 5720 Integrity Dr city: Millington
line2: st: TN 38055

10. Telephone (Area code and local number)

11. Date authorized (mm/dd/yyyy)

04/01/2014

12. Send one copy of your report to:

U.S. Department of Labor
Office of Workers' Compensation Programs

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent

name: CCSI
line1: P.O. Box 541388 city: Dallas
line2: st: TX 75354

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 65 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20CFR 702.419). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, N.W., Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form LS-1
Rev. October 2010

Physician will complete 2nd page of this form*

HOW TO FILL OUT FORM LS-210

- The employer uses this form to notify the Department of Labor of time lost due to injury
- The LS-210 can be completed on the workers' compensation website by clicking on LS-210 tab and clicking new. You must have the employee's assigned claim number to enter information. **NOTE:** The first date of lost time does not include the day of injury.

Complete the following fields:

(1 – 6 and 12 -13 are pre-populated)

7. Initial Period of Disability (Use Inclusive Dates for A and B)		
A. From	B. To	C. Date Returned to Work:
01/02/2014		01/10/2014
8. If this report covers a period of disability after the date shown in item 7C. State each subsequent period of disability. Use inclusive dates for A and B.		
A. From	B. To	C. Date returned to work
9. Did employee receive medical attention?		
<input checked="" type="radio"/> Yes <input type="radio"/> No		
If Yes, give dates, names and addresses of doctors and hospitals providing. If No, explain.		
DR. FRIEND, 789 PAWNEE, MILLINGTON TN 901-589-6987		
10. Was employee treated by his or her choice of physician?		
<input checked="" type="radio"/> Yes <input type="radio"/> No		
11. Was form LS-1 given to employee when injury was reported to you?		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

- After completing and submitting form, print a copy and mail or fax to New York OWCP office that is provided in the point of contact listing.

OSHA

Forms for Recording

Work-Related Injuries and Illnesses

Dear Employer:

This booklet includes the forms needed for maintaining occupational injury and illness records. Many but not all employers must complete the OSHA injury and illness recordkeeping forms on an ongoing basis. Employers in State Plan States should check with their State Plan to see if the exemptions below apply.

Employers with 10 or fewer employees throughout the previous calendar year do not need to complete these forms. Said another way, if there are more than 10 employees at any time during that calendar year, the employer may come under the requirement. When counting employees, you must include full-time, part-time, temporary, and seasonal workers. This exemption is based on the employment of the entire company rather than the establishment. For example, if a company has two establishments, one with 5 employees and one with 7 employees, the company must fill out the forms for each establishment because the company employment is greater than 10.

In addition to the small employer exemption, there is an exemption for establishments classified in certain industries. For example, the forms do not need to be completed for restaurants, banks, and medical offices. A complete list of exempt industries can be found on the OSHA web page at www.osha.gov.

Establishments normally exempt from keeping the OSHA forms must complete the forms if they are informed in writing to do so by the Bureau of Labor Statistics or OSHA. Also, exempt establishments must report to the local OSHA office within 8 hours any fatality or incident involving three or more in-patient hospitalizations.

The Occupational Safety and Health Administration shares with you the goal of preventing injuries and illnesses in our nation's workplaces. Accurate injury and illness records will help us achieve that goal.

Occupational Safety and Health Administration
U.S. Department of Labor



U.S. Department of Labor
Occupational Safety and Health Administration

What's Inside...

In this package, you'll find everything you need to complete OSHA's *Log* and the *Summary of Work-Related Injuries and Illnesses* for the next several years. On the following pages, you'll find:

▼ **An Overview: Recording Work-Related Injuries and Illnesses** — General instructions for filling out the forms in this package and definitions of terms you should use when you classify your cases as injuries or illnesses.

▼ **How to Fill Out the Log** — An example to guide you in filling out the *Log* properly.

▼ **Log of Work-Related Injuries and Illnesses** — Several pages of the *Log* (but you may make as many copies of the *Log* as you need.) Notice that the *Log* is separate from the *Summary*.

▼ **Summary of Work-Related Injuries and Illnesses** — Removable *Summary* pages for easy posting at the end of the year. Note that you post the *Summary* only, not the *Log*.

▼ **Worksheet to Help You Fill Out the Summary** — A worksheet for figuring the average number of employees who worked for your establishment and the total number of hours worked.

▼ **OSHA's 301: Injury and Illness Incident Report** — A copy of the OSHA 301 to provide details about the incident. You may make as many copies as you need or use an equivalent form.

Take a few minutes to review this package. If you have any questions, visit us online at www.osha.gov or call your local OSHA office. We'll be happy to help you.





An Overview: Recording Work-Related Injuries and Illnesses

The Occupational Safety and Health (OSH) Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Use these definitions when you classify cases on the Log. OSHA's recordkeeping regulation (see 29 CFR Part 1904) provides more information about the definitions below.

The *Log of Work-Related Injuries and Illnesses* (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened. The *Summary* — a separate form (Form 300A) — shows the totals for the year in each category. At the end of the year, post the *Summary* in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace.

Employers must keep a *Log* for each establishment or site. If you have more than one establishment, you must keep a separate *Log* and *Summary* for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury and illness records. For more information, see 29 Code of Federal Regulations Part 1904.35, *Employee Involvement*.

Cases listed on the *Log of Work-Related Injuries and Illnesses* are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case on the *Log* does not mean that the employer or worker was at fault or that an OSHA standard was violated.

When is an injury or illness considered work-related?

An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is

presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. See 29 CFR Part 1904.5(b)(2) for the exceptions. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment. See 29 CFR Part 1904.5(b)(1).

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in:

- ▼ death,
- ▼ loss of consciousness,
- ▼ days away from work,
- ▼ restricted work activity or job transfer, or
- ▼ medical treatment beyond first aid.

You must also record work-related injuries and illnesses that are significant (as defined below) or meet any of the additional criteria listed below.

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum. See 29 CFR 1904.7.

What are the additional criteria?

You must record the following conditions when they are work-related:

- ▼ any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material;
- ▼ any case requiring an employee to be medically removed under the requirements of an OSHA health standard;
- ▼ tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional after exposure to a known case of active tuberculosis;
- ▼ an employee's hearing test (audiogram) reveals 1) that the employee has experienced a Standard Threshold Shift (STS) in hearing in one or both ears (averaged at 2000, 3000, and 4000 Hz) and 2) the employee's total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 Hz) in the same ear(s) as the STS.

What is medical treatment?

Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are NOT recordable:

- ▼ visits to a doctor or health care professional solely for observation or counseling;

What do you need to do?

1. Within 7 calendar days after you receive information about a case, decide if the case is recordable under the OSHA recordkeeping requirements.
2. Determine whether the incident is a new case or a recurrence of an existing one.
3. Establish whether the case was work-related.
4. If the case is recordable, decide which form you will fill out as the injury and illness incident report.

You may use *OSHA's 301: Injury and Illness Incident Report* or an equivalent form. Some state workers compensation, insurance, or other reports may be acceptable substitutes, as long as they provide the same information as the OSHA 301.

How to work with the Log

1. Identify the employee involved unless it is a privacy concern case as described below.
2. Identify when and where the case occurred.
3. Describe the case, as specifically as you can.
4. Classify the seriousness of the case by recording the most serious outcome associated with the case, with column G (Death) being the most serious and column I (Other recordable cases) being the least serious.
5. Identify whether the case is an injury or illness. If the case is an injury, check the injury category. If the case is an illness, check the appropriate illness category.



- ▼ diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes; and
- ▼ any procedure that can be labeled first aid. (See *below for more information about first aid.*)

What is first aid?

If the incident required only the following types of treatment, consider it first aid. Do NOT record the case if it involves only:

- ▼ using non-prescription medications at non-prescription strength;
- ▼ administering tetanus immunizations;
- ▼ cleaning, flushing, or soaking wounds on the skin surface;
- ▼ using wound coverings, such as bandages, BandAids™, gauze pads, etc., or using SteriStrips™ or butterfly bandages;
- ▼ using hot or cold therapy;
- ▼ using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
- ▼ using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards);
- ▼ drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters;
- ▼ using eye patches;
- ▼ using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
- ▼ using irrigation, tweezers, cotton swab or other simple means to remove splinters or foreign material from areas other than the eye;

- ▼ using finger guards;
- ▼ using massages;
- ▼ drinking fluids to relieve heat stress.

How do you decide if the case involved restricted work?

Restricted work activity occurs when, as the result of a work-related injury or illness, an employer or health care professional keeps, or recommends keeping, an employee from doing the routine functions of his or her job or from working the full workday that the employee would have been scheduled to work before the injury or illness occurred.

How do you count the number of days of restricted work activity or the number of days away from work?

Count the number of calendar days the employee was on restricted work activity or was away from work as a result of the recordable injury or illness. Do not count the day on which the injury or illness occurred in this number. Begin counting days from the day **after** the incident occurs. If a single injury or illness involved both days away from work and days of restricted work activity, enter the total number of days for each. You may stop counting days of restricted work activity or days away from work once the total of either or the combination of both reaches 180 days.

Under what circumstances should you NOT enter the employee's name on the OSHA Form 300?

You must consider the following types of injuries or illnesses to be privacy concern cases:

- ▼ an injury or illness to an intimate body part or to the reproductive system,
 - ▼ an injury or illness resulting from a sexual assault,
 - ▼ a mental illness,
 - ▼ a case of HIV infection, hepatitis, or tuberculosis,
 - ▼ a needlestick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material (see 29 CFR Part 1904.8 for definition), and
 - ▼ other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log.
- You must not enter the employee's name on the OSHA 300 Log for these cases. Instead, enter "privacy case" in the space normally used for the employee's name. You must keep a separate, confidential list of the case numbers and employee names for the establishment's privacy concern cases so that you can update the cases and provide information to the government if asked to do so.
- If you have a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee's name has been omitted, you may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. You must enter enough information to identify the cause of the incident and the general severity of the

injury or illness, but you do not need to include details of an intimate or private nature.

What if the outcome changes after you record the case?

If the outcome or extent of an injury or illness changes after you have recorded the case, simply draw a line through the original entry or, if you wish, delete or white-out the original entry. Then write the new entry where it belongs. Remember, you need to record the most serious outcome for each case.

Classifying injuries

An injury is any wound or damage to the body resulting from an event in the work environment.

Examples: Cut, puncture, laceration, abrasion, fracture, bruise, contusion, chipped tooth, amputation, insect bite, electrocution, or a thermal, chemical, electrical, or radiation burn. Sprain and strain injuries to muscles, joints, and connective tissues are classified as injuries when they result from a slip, trip, fall or other similar accidents.



Classifying illnesses

Skin diseases or disorders

Skin diseases or disorders are illnesses involving the worker's skin that are caused by work exposure to chemicals, plants, or other substances.

Examples: Contact dermatitis, eczema, or rash caused by primary irritants and sensitizers or poisonous plants; oil acne; friction blisters; chrome ulcers; inflammation of the skin.

Respiratory conditions

Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dust, gases, vapors, or fumes at work.

Examples: Silicosis, asbestosis, pneumonitis, pharyngitis, rhinitis or acute congestion;

farmer's lung; beryllium disease, tuberculosis, occupational asthma, reactive airways dysfunction syndrome (RADS), chronic obstructive pulmonary disease (COPD), hypersensitivity pneumonitis, toxic inhalation injury, such as metal fume fever, chronic obstructive bronchitis, and other pneumoconioses.

Poisoning

Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues, other bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body.

Examples: Poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other gases; poisoning by benzene, benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays, such as parathion or lead arsenate; poisoning by other chemicals, such as formaldehyde.

Hearing Loss

Noise-induced hearing loss is defined for recordkeeping purposes as a change in hearing threshold relative to the baseline audiogram of an average of 10 dB or more in either ear at 2000, 3000 and 4000 hertz, and the employee's total hearing level is 25 decibels (dB) or more above audiometric zero (also averaged at 2000, 3000, and 4000 hertz) in the same ear(s).

All other illnesses

All other occupational illnesses.

Examples: Heatstroke, sunstroke, heat exhaustion, heat stress and other effects of environmental heat; freezing, frostbite, and other effects of exposure to low temperatures; decompression sickness; effects of ionizing radiation (isotopes, x-rays, radium); effects of nonionizing radiation (welding flash, ultra-violet rays, lasers); anthrax; bloodborne pathogenic diseases, such as AIDS, HIV, hepatitis B or hepatitis C; brucellosis; malignant or benign tumors; histoplasmosis; coccidioidomycosis.

When must you post the Summary?

You must post the *Summary* only — not the *Log* — by February 1 of the year following the year covered by the form and keep it posted until April 30 of that year.

How long must you keep the Log and Summary on file?

You must keep the *Log* and *Summary* for 5 years following the year to which they pertain.

Do you have to send these forms to OSHA at the end of the year?

No. You do not have to send the completed forms to OSHA unless specifically asked to do so.

How can we help you?

If you have a question about how to fill out the *Log*,

- ▼ visit us online at www.osha.gov or
- ▼ call your local OSHA office.



Optional

Calculating Injury and Illness Incidence Rates

What is an incidence rate?

An incidence rate is the number of recordable injuries and illnesses occurring among a given number of full-time workers (usually 100 full-time workers) over a given period of time (usually one year). To evaluate your firm's injury and illness experience over time or to compare your firm's experience with that of your industry as a whole, you need to compute your incidence rate. Because a specific number of workers and a specific period of time are involved, these rates can help you identify problems in your workplace and/or progress you may have made in preventing work-related injuries and illnesses.

How do you calculate an incidence rate?

You can compute an occupational injury and illness incidence rate for all recordable cases or for cases that involved days away from work for your firm quickly and easily. The formula requires that you follow instructions in paragraph (a) below for the total recordable cases or those in paragraph (b) for cases that involved days away from work, and for both rates the instructions in paragraph (c).

(a) To find out the total number of recordable injuries and illnesses that occurred during the year, count the number of line entries on your OSHA Form 300, or refer to the OSHA Form 300A and sum the entries for columns (G), (H), (I), and (J).

(b) To find out the number of injuries and illnesses that involved days away from work, count the number of line entries on your OSHA Form 300 that received a check mark in column (H), or refer to the entry for column (H) on the OSHA Form 300A.

(c) The number of hours all employees actually worked during the year. Refer to OSHA Form 300A and optional worksheet to calculate this number.

You can compute the incidence rate for all recordable cases of injuries and illnesses using the following formula:

Total number of injuries and illnesses X 200,000 ÷ Number of hours worked by all employees = Total recordable case rate

(The 200,000 figure in the formula represents the number of hours 100 employees working 40 hours per week, 50 weeks per year would work, and provides the standard base for calculating incidence rates.)

You can compute the incidence rate for recordable cases involving days away from work, days of restricted work activity or job transfer (DART) using the following formula:

Number of entries in column H + Number of entries in column I X 200,000 ÷ Number of hours worked by all employees = DART incidence rate

You can use the same formula to calculate incidence rates for other variables such as cases involving restricted work activity (column (I) on Form 300A), cases involving skin disorders (column (M-2) on Form 300A), etc. Just substitute the appropriate total for these cases, from Form 300A, into the formula in place of the total number of injuries and illnesses.

What can I compare my incidence rate to?

The Bureau of Labor Statistics (BLS) conducts a survey of occupational injuries and illnesses each year and publishes incidence rate data by

various classifications (e.g., by industry, by employer size, etc.) You can obtain these published data at www.bls.gov/iif or by calling a BLS Regional Office.

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

Worksheet

Total number of injuries and illnesses

X 200,000

÷

Number of hours worked by all employees

=

Total recordable case rate

Number of entries in Column H + Column I

X 200,000

÷

Number of hours worked by all employees

=

DART incidence rate

Save Input

Reset



If You Need Help...

If you need help deciding whether a case is recordable, or if you have questions about the information in this package, feel free to contact us. We'll gladly answer any questions you have.

▼ Visit us online at www.osha.gov

▼ Call your OSHA Regional office and ask for the recordkeeping coordinator

or

▼ Call your State Plan office

Federal Jurisdiction

Region 1 - 617 / 565-9860
Connecticut; Massachusetts; Maine; New Hampshire; Rhode Island

Region 2 - 212 / 337-2378
New York; New Jersey

Region 3 - 215 / 861-4900
DC; Delaware; Pennsylvania; West Virginia

Region 4 - 678 / 237-0400
Alabama; Florida; Georgia; Mississippi

Region 5 - 312 / 353-2220
Illinois; Ohio; Wisconsin

Region 6 - 972 / 850-4145
Arkansas; Louisiana; Oklahoma; Texas

Region 7 - 816 / 283-8745
Kansas; Missouri; Nebraska

Region 8 - 720 / 264-6550
Colorado; Montana; North Dakota; South Dakota

Region 9 - 415 / 625-2547

Region 10 - 206 / 553-5930
Idaho

State Plan States

Alaska - 907 / 269-4957
Puerto Rico - 787 / 754-2172

Arizona - 602 / 542-5795
South Carolina - 803 / 734-9669

California - 415 / 703-5100
Tennessee - 615 / 741-2793

*Connecticut - 860 / 566-4380
Utah - 801 / 530-6901

Hawaii - 808 / 586-9100
Vermont - 802 / 828-2765

*Illinois - 217 / 782-6206
Virginia - 804 / 786-6613

Indiana - 317 / 232-2688
*Virgin Islands - 340 / 772-1315

Iowa - 515 / 281-3661
Washington - 360 / 902-5554

Kentucky - 502 / 564-3070
Wyoming - 307 / 777-7786

Maryland - 410 / 527-4465

Michigan - 517 / 322-1848
*Public Sector only

Minnesota - 651 / 284-5050

Nevada - 702 / 486-9020

*New Jersey - 609 / 984-1389

New Mexico - 505 / 827-4230

*New York - 518 / 457-2574

North Carolina - 919 / 807-2875

Oregon - 503 / 378-3272

Forms

Workers' Compensation What Happens Next?

Your activity workers' compensation coordinator is _____.
Located at _____ and his/her phone number is
_____. If you have questions, contact this person or your
supervisor.

If your injury/illness requires medical treatment, you may go to a physician of your own choosing. You **may not** change physicians after the initial choice unless the Third Party Administrator (TPA) has given prior consent for the change.

If you have a lost time claim due to your injury/illness, you will receive workers' compensation benefits for lost time of scheduled shift if your workers' compensation claim is approved. Remember you must continue to communicate with your workers' compensation point of contact until your case is closed.

You will also be contacted by CNIC's TPA, which is Contract Claims Services, Inc. (CCSI) within 24 hours of receipt of the claim.





Workers' Compensation Supervisor's Checklist

Employee: _____ Supervisor: _____

Date of Injury: _____

Please submit all forms to the workers' compensation POC on the same day of injury.
However, in the event the employee needs immediate attention, forms can be completed after medical care is given to the employee.

Please check:

Report only:

- LS-202 complete and submitted to the workers' compensation POC
- Parking Lot Injury Check list (if applicable)
- What Happens Next Form

Report with Medical

- LS-202 complete and submitted to the workers' compensation POC
- LS-1 (this form is *only* given to the employee and used the same day of injury)
- Parking Lot Injury Check list (if applicable)
- Choice of Physician Statement
- Employee's Consent and Authorization to release Medical and/or Dental Records Form
- What Happens Next Form

Return to Work with Restrictions

If the employee has returned to work with restrictions (light duty), the following form must be completed:

- Light Duty Advisory Form



Part A - Authorization

OMB No. 1240-0029

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the **employee's choice** ("See item below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course of employment.

Mark either box A or B in item 7. The original and at least two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the District Director and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:

- A Longshore and Harbor Workers' Compensation Act
- B Defense Base Act
- C Nonappropriated Fund Instrumentalities Act
- D Outer Continental Shelf Lands Act

2. Name and address of physician or medical facility authorized to provide medical service

* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diagnose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name: _____
 line1: _____ city: _____
 line2: _____ st: _____

3. Employee's Name

4. Date of Injury (mm/dd/yyyy)

5. Occupation

6. How accident or illness occurred

7. You are authorized to provide medical services to the employee as follows:

- A If you believe the condition is related to the injury, or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.
- B If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

You are requested to submit a written report of first treatment within 10 days to the District Director at the Office named in item 12 below (See back of this form for Instructions as to medical report and the submission of your charges).

8. Signature and title of authorizing official (Sign all copies)

9. Name and address of employer

name: _____
 line1: _____ city: _____
 line2: _____ st: _____

10. Telephone (Area code and local number)

11. Date authorized (mm/dd/yyyy)

12. Send one copy of your report to:

U.S. Department of Labor
Office of Workers' Compensation Programs

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent

name: _____
 line1: _____ city: _____
 line2: _____ st: _____

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 65 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. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20CFR 702.419). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, N.W., Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Part B - Attending Physician's Report of Injury and Treatment

Instructions To Physician: This initial report should be completed and submitted within 10 days. Mail the original to the District Director (see Item 12 for address), and a copy to the company listed in Item 13. Subsequent reports should be made regularly on form LS-204 and/or in narrative form while the employee is in your care. Please read item 7 on the front of this form. Your Social Security Number is voluntary and is used for identification purposes only.

14. What history of injury or disease did employee give you?

15. Is there any history or evidence of pre-existing injury, disease, or physical impairment?
 No Yes - Please describe _____

16. What are your findings (include results of x-rays, laboratory tests, etc.)?

17. What is your diagnosis?

18. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain your answer if there is doubt.)
 Yes No _____

19a. Did injury require hospitalization? No Yes - Complete b, c, d
 b. Name of hospital _____
 c. Date admitted (mm/dd/yyyy) _____
 d. Date discharged _____

20. Is additional hospitalization required?
 Yes No

21. Surgery (If any, describe type)

22. Date surgery performed (mm/dd/yyyy)

23. What type of treatment did you provide other than hospitalization or surgery?

24. What permanent effects of the injury, if any, do you anticipate?

25. Date of first examination (mm/dd/yyyy)

26. Date(s) of treatment (mm/dd/yyyy)

27. Date of discharge from treatment (mm/dd/yyyy)

28. Period of disability (if termination date unknown - so indicate)
 Total disability: From _____ To _____
 Partial disability: From _____ To _____

29. Date employee able to resume work
 To light work _____
 To regular work _____

30. If employee is able to resume work, has he/she been advised? No Yes - Furnish date advised (mm/dd/yyyy) _____

31. If employee is able to resume only light work, indicate physical limitations and the type of work which can reasonably be performed with these limitations.

32. Remarks and recommendation for future care, if indicated.

33. Do you specialize? No Yes - State specialty _____

34. Signature and typed name of physician

35. Address and phone number

36. Physician's Federal Tax ID number

37. Date of this report (mm/dd/yyyy)

38. Medical bill (Charges for your services may be presented in the space below or on your billhead stationery.)

Date or period of treatment	Services and supplies must be itemized	Qty. or No.	Unit price		Amount
			Cost	Per	
Total					

**Employer's First Report of Injury
or Occupational Illness**
(See instructions on reverse)

U.S. Department of Labor

Office of Workers' Compensation Programs



OMB No. 1240-0003

1. OWCP No.		2. Carrier's No.		3. Date and Time of Accident (mm/dd/yyyy) (hh:mm am/pm)	
4. Name of injured/deceased employee (Type or print - first, M.I., last) First Name M.I. Last Name Telephone				5. Employee's address (No., street, city, state, ZIP, country) street: City: st: Zip: City:	
6. Injury is reported under the following Act (Mark one) A <input type="checkbox"/> Longshore and Harbor Workers' Compensation Act B <input type="checkbox"/> Nonappropriated Fund Instrumentalities Act C <input type="checkbox"/> Outer Continental Shelf Lands Act D <input type="checkbox"/> Defense Base Act 1. Contracting Agency 2. Contract Number		7. Indicate where injury occurred (Longshore Act only) (Mark one) A <input type="checkbox"/> Aboard vessel or over navigable waters B <input type="checkbox"/> Pier/Wharf C <input type="checkbox"/> Dry dock D <input type="checkbox"/> Marine terminal E <input type="checkbox"/> Building way F <input type="checkbox"/> Marine railway G <input type="checkbox"/> Other adjoining area		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
				9. Date of birth (mm/dd/yyyy)	
				10. Social security no. (Required by law)	
				11. Did injury cause death? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, skip to 16	
				12. Did injury cause loss of time beyond day or shift of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				13. Date and hour employee first lost time because of injury Date (mm/dd/yyyy) Time (hh:mm am/pm)	
14. Did employee stop work immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Date & hour empl returned to work (mm/dd/yyyy) (hh:mm am/pm)		16. Was employee doing usual work when injured/killed? (if no, explain in Item 26) <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Did injury/death occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Dept. in which employee normally works(ed)		19. Occupation	
20. Date and hour pay stopped (mm/dd/yyyy) (hh:mm am/pm)		21. Which days usually worked per week? (Mark (X) days) S M T W T F S		22. Date employer or foreman first knew of accident. (mm/dd/yyyy) (hh:mm am/pm)	
23. Wages or earnings (include overtime, allowances, etc.) a. Hourly b. Daily c. Weekly d. Yearly		24. Exact place where accident occurred (See instructions on reverse). This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.		25. How was knowledge of accident or occupational illness gained?	
26. Describe in full how the accident occurred. (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.)					
27. Nature of Injury (Name part of body affected - fractured left leg, bruised right thumb, etc.) If there was amputation of a member of the body, describe.					
28a. Has medical attention been authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No		28b. LS-1 issued? Yes <input type="checkbox"/> No <input type="checkbox"/>		29. Enter date of authorization.	
				30. Was first treating physician chosen by employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				31. Has insurance carrier been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ Name of:			Address - Enter number, street, city, state, zip code		
32. Physician					
33. Hospital					
34. Insurance Carrier					
35. Employer					
36. Employer's Business		37. Signature of person authorized to sign for employer		Phone number	
38. Official title and phone number of person signing this report		Name of person signing this report		39. Date of this report (mm/dd/yyyy)	

Form LS-202
Rev. Oct. 2010

This report is to be filed in duplicate with the District Director in the appropriate district office of the Office of Workers' Compensation Programs and is required by 33 U.S.C. 930(a). File form within 10 days from the date of injury or death or from the date the employer first has knowledge of an injury or death. Under the law all medical treatment and compensation must be furnished by the employer or its insurance company. Treatment must be by a physician chosen by the employee, unless the physician is on a list of physicians currently not authorized by the Department of Labor to render medical care under the Act. Compensation payments become due and are payable on the 14th day after the employer first has knowledge of the injury or death. Penalties may be charged for failure to comply with provisions of the law. The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

REPORTABLE INJURY – Any accidental injury which causes loss of one or more shifts of work or death allegedly arising out of and in the course of employment, including any occupational disease or infection believed or alleged to have arisen naturally out of such employment, or as a natural or unavoidable result from an accidental injury. If the employer controverts the right to compensation it must also file a notice of controversion with the District Director within 14 days after it has knowledge of the alleged injury or death.

Item 6 – A. Longshore and Harbor Workers' Compensation Act covers employees injured while engaged in maritime employment upon the navigable waters of the United States (including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, or building a vessel); - employees injured upon the navigable waters of the United States and other described areas who at the time of injury were engaged in maritime employment and are not otherwise specifically excluded under the Act (33 U.S.C. 902).

B. Defense Base Act covers any employment (1) at military, air, and naval bases acquired by the United States from foreign countries; (2) on lands occupied or used by the United States for military or naval purposes outside the continental limits of the United States; (3) upon any public work in any Territory or possession outside the continental United States under a contract of a contractor with the United States; (4) under a contract entered into with the United States where such contract is to be performed outside the continental United States and at places not within the areas described in (1), (2), and (3) above for the purpose of engaging in public work; (5) under certain contracts approved and financed by the United States under the Mutual Security Act of 1954, as amended; and (6) in the service of American employers providing welfare or similar services for the benefit of the Armed Forces outside the Continental United States.

C. Nonappropriated Fund Instrumentalities Act covers employees of nonappropriated fund instrumentalities of the Armed forces, e.g., post exchanges, motion picture service, etc.

D. Outer Continental Shelf Lands Act covers employees of private employers engaged in operations conducted on the Outer Continental Shelf for the purpose of exploring for, developing, removing, or transporting by pipeline the natural resources of submerged lands.

Item 24 – "Exact place where accident occurred" requires the nearest street address, city and town. In addition -

- If on a vessel,
Give place on vessel where injury happened (Deck, hold, tweendeck, engine room, etc.) Name of vessel
- If either on an adjoining pier, wharf, dry dock, terminal building way, marine railway, or other area customarily used in loading, unloading, repairing, or building a vessel

Name or number of pier, dry dock, marine railway, etc.
Name of the terminal or shipyard
Nearest street address – City and State
- If injury or death is reported under the Defense Base Act, give the name of the country where injury or death occurred.
- If on the Outer Continental Shelf,

Give drilling site and block number
Area name (e.g. West Delta Area)
Federal Lease Number, State Lease Number
Distance from and name of nearest land,
name of State

NOTE: FILING THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY UNDER THE COMPENSATION ACT. Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails to submit this report when required or knowingly or willfully makes a false statement or misrepresentation in this report shall be subject to a civil penalty not to exceed \$11,000 for each such failure, refusal, false statement, or misrepresentation. [33 U.S.C.930(e)] This report shall not be evidence of any fact stated herein in any proceeding in respect to any such injury or death on account of which the report is made. [33 U.S.C. 930(c)]

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 15 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. Use of this is optional, however furnishing the information is required in order to obtain and/or retain benefits (33U.S.C. 930(a)). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U. S. Department of Labor, 200 Constitution Avenue, N.W., Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

Employer's Supplementary Report of Accident or Occupational Illness

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



Print | Reset

Notice: This Report must be filed promptly with the District Director in every case in which (1) Form LS-202 does not show date injured employee returned to work, and (2) each time injured employee has returned to work and later becomes disabled for work (33 U.S.C.930(b)). If the employee was disabled for work more than 3 days, compensation payments should be reported on Forms LS-206 and LS-208. Medical reports must be sent to the District Director promptly following first treatment and thereafter while treatment continues. Please type or print all information. (if additional space is needed, use back of form.) The information will be used to determine entitlement to benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0031

For Office Use

1. OWCP No.

2. Carrier's No.

3. Name of injured employee (First, middle initial, last)

4. Date of accident (Month, day, year)

5. Address of injured employee (Number and Street, City, State, ZIP code)

line 1:

line 2:

city: st: zip:

6. Name and address of your insurance carrier

city: st: zip:

7. Initial Period of Disability (Use Inclusive Dates for a and b)

a. From (Month, day, year)

b. To (Month, day, year)

c. Date returned to work (Month, day, year)

8. If this report covers a period of disability after the date shown in item 7c, state each subsequent period of disability. Use inclusive dates for a. and b.

a. From (Month, day, year)	b. To (Month, day, year)	c. Date returned to work (Month, day, year)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

9. Did employee receive medical attention?

a. Yes - Give dates, names and addresses of doctors and hospitals providing treatment.

b. No - Explain

10. Was employee treated by his or her choice of physician? Yes No

11. Was form LS-1 given to employee when injury was reported to you? Yes No

12. Name of employer (Firm Name)

13. Employer's address (Number and Street, City, State, ZIP code)

city: st: zip:

country:

14. Signature of person authorized to sign for employer

15. Name and official title of person signing

name:

title:

16. Date of report (Month, day, year)

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**

Form LS-210
 Rev. Oct. 1998



Employee

(Commander Navy Installations Command)

CHOICE OF PHYSICIAN STATEMENT

DATE COMPLETED	DATE OF INJURY/ILLNESS
----------------	------------------------

EMPLOYEE NAME

<p>I choose as my physician (Emergency Room Physician excluded)</p> <p>PHYSICIAN'S NAME _____</p> <p>OFFICE NAME (if applicable) _____</p> <p>ADDRESS _____</p> <p>TELEPHONE NUMBER _____</p> <p>CITY, STATE, ZIP _____</p> <p>SPECIALTY (IF KNOWN) _____</p>

<p>_____ SIGNATURE OF EMPLOYEE/CLAIMANT</p> <p>_____ ADDRESS</p> <p>_____ CITY/STATE/ZIP</p> <p>_____ TELEPHONE NUMBER</p>
--

**Employee's Consent & Authorization
to release Medical and/or Dental Records**

I, _____, hereby consent to and authorize any hospital, medical, clinic, state agency, military facility, Veterans Administration, physician, surgeon, chiropractor, physical therapist, dentist, oral surgeon and/or other health care provider who has examined or treated me, or any hospital or facility where I may have been examined or treated, whether past, current and/or future, to release to my Employer, Department of the Navy and/or its authorized representatives or agents, my medical records for us in conjunction with my workers' compensation claim.

The term medical records includes, but is not limited to the following:

Any and all medical records; progress notes; nurse's notes; narrative reports; physical therapist notes; emergency room records; test results; x-ray, CT, MRI and/or any other films or diagnostic results that establish the presence or absence of a physical, mental, physiological and/or psychological injury, condition, disease, illness, defect or sensitivity, including the presence and/or absence of drug and/or alcohol dependency; and/or any records which set forth the diagnosis, evaluation and/or treatment of an injury, condition, disease, illness, defect or sensitivity ; physical therapy, work hardening, weight control, and/or other similar records of diagnosis, treatment and/or progress; functional capacity evaluation, Cybex, tests, and other related reports and evaluations.

These medical records are to be furnished to Employer and/or its authorized representatives and/or agents, including claims adjusters, medical and/or vocational rehabilitation specialists, Independent Medical Examining physicians, surgeons, dentists, oral surgeons, or any other health care provider who needs such information to render a medical and/or vocational opinion.

I understand that this information is to be released only for the purpose of evaluation and administration of any claim(s) for workers' compensation benefits and/or temporary or long-term disability retirement benefits.

This is to certify that a photostatic copy of this medical authorization form is as valid and as binding as an original authorization form bearing my signature.

Signature of Claimant	Date	Signature of Witness	Date
-----------------------	------	----------------------	------

Printed Name of Claimant	Date	Printed Name of Witness	Date
--------------------------	------	-------------------------	------

Return this form to: Contract Claims Services, Inc.
P.O. Box 541328 Dallas, TX 75354-1328

Adj. Code _____ File No. _____

Temporary Prescription Services

Attention Injured Worker

- On your first visit, please give this notice to any pharmacy listed below to expedite the processing of your approved workers' compensation prescriptions. (Based on the established parameters by your employer.)
- Questions or need assistance locating a participating pharmacy: Call the Express Scripts Contact Center at 800-945-5951.

Atencion Trabajador Lesionado:

- Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).
- Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 866-945-5951.

Attention Supervisor: Please complete the following information for the injured worker.

<u>Express Scripts</u>	<u>Employee Information</u>
<p>ID #: SSN to be presented to the pharmacy at the time prescription is filled</p> <p>Date of Injury: <u>MM/DD/YYYY</u></p> <p>Group #: KQFA</p> <p>Employee Date of Birth: <u>MM/DD/YYYY</u></p>	<p>First <u> </u> M <u> </u> Last <u> </u></p> <p>Mailing Address</p> <p>Street Address <u> </u> <u> </u> <u> </u> <u> </u></p> <p>or PO Box <u> </u> City <u> </u> State <u> </u> Zip <u> </u></p> <p>Employer Name</p> <p><u> </u></p>

Attention Pharmacist

- Express Scripts administers this workers' compensation prescription program. Follow the steps below to submit a claim.
- For assistance, call the Express Scripts Contact Center at 888-786-9640.

Pharmacy Processing Steps	
Step 1	Enter bin number 003858
Step 2	Enter processor control A4
Step 3	Enter the group number as it appears above
Step 4	Enter the injured worker's 9 digit ID#
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of injury (enter in PA field in the format ccyyymmdd)

Participating Pharmacy Chains

A & P	Cash Wise	Food Lion	Medic Discount	Randalls	Texas Oncology
Acme Pharmacy	Coborn's	Fred's	Medicap	Rite Aid	Srvs
Albertson's	Costco	Gemmel	Medistat	Rosauers	The Pharm
Albertson's/Acme	Cub	Giant	Meijer	Rx Express	Thrifty White
Albertson's/Osco	CVS	Giant Eagle	Minyard	RXD	Times
Albertson's/Sav-On	D&W	Giant Foods	NCS HealthCare	Safeway	Tom Thumb
Amerisource	Dahl's	Hannaford	Neighborcare	Sam's Club	Tops
Bergen	Dierbergs	Harris Teeter	Network	Sav-On	Ukrop's
Anchor Pharmacies	Discount Drugmart	H-E-B	Pharmaceuticals	Save Mart	United Drugs
Arrow	Doc's Drugs	Hi-School	Northeast	Schnucks	United
Aurora	Dominicks	Pharmacy	Pharmacy	Scolari's	Supermarkets
Bartell Drugs	Drug Emporium	Hy-Vee	Services	Sedano	Vons
Bigg's	Drug Fair	Jewel/Osco	Osco	Shaw's	Waldbaums
Bi-Lo	Drug Town	Kash n Karry	P & C Food	Shop 'N Save	Wal-Mart
Bi-Mart	Drug World	Keltsch	Markets	Shopko	Wegmans
BJ's Wholesale	Eckerd	Kerr	Pamida	ShopRite	Weis
Club	Econofoods	Kmart	Park Nicollet	Snyder	Winn Dixie
Brooks	EPIC Pharmacy	Knight Drugs	Pathmark	Stop & Shop	
Brookshire	Network	Kroger	Pavilions	Sun Mart	
Brothers	FamilyMeds	LeaderNet (PSAO)	Price Chopper	Super Fresh	
Brookshire Grocery	Farm Fresh	Longs Drug Store	Publix	Super Rx	
Bruno	Farmer Jack	Major Value	Quality Markets	Target	
Carrs	Food City	Marsh Drugs	Raley's		

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.



Employer

Modified/Alternative Work

To: CONTRACT CLAIMS SERVICES, INC./P & FRD

From: _____ Location/NAFI # _____

Date: _____

Subject: Availability of Work

Our employee, _____, was injured on _____

Mark one:

- Light or modified duty IS AVAILABLE
- Light or modified duty IS NOT AVAILABLE

Mark one:

- The duty will be provided in the employee's regular job position.
- The duty will be provided in an alternate job position.

Printed Name/Position of Person Completing Form

Phone Number

Signature of Person Completing Form

Date Signed

☑ SCAN A COPY OF THIS FORM TO CCSI



TELEPHONE LOG

Name of Employee

Date of Injury

Time/Date of Phone Call

Called by

Comments

TELEPHONE LOG

Name of Employee

Date of Injury

Time/Date of Phone Call

Called by

Comments

TELEPHONE LOG

Name of Employee

Date of Injury

Time/Date of Phone Call

Called by

Comments



Employer

PARKING LOT INJURY CHECKLIST

Employee Name _____

TASK	DATE COMPLETED
Workers' compensation POC obtains written statement from employee	
A "map" of the accident scene is obtained from the employee	
QUESTIONS	ANSWER
Was the claimant on a work-related errand?	
Did MWR provide the transportation?	
Does the employee's position with CNIC require travel? And, if so, was he/she in the course and scope of employment at the time of the incident?	
Could the weather have contributed to the incident? If so, what was the weather?	
What time did the incident occur?	
Was the employee coming into work or leaving work?	
Is the employee required to enter/exit the workplace through an "employee only" Entrance/exit? If so, how far from the entrance/exit was the employee at the time of the accident?	
Did the employee park in a designated parking area (an "employee lot")?	
Was the employee on lunch, break, or a personal errand?	
Does the employee "clock-in" and "clock-out"? If so, what time does the employee "clock-in" and "clock-out"?	
Was the employee working just prior to the incident?	
Who maintains the area where the incident occurred (CNIC or the military installation)? If CNIC, what responsibility does CNIC have regarding the maintenance of the area, i.e., snow/ice removal, sweeping, etc?	
Who owns the area where the incident occurred (CNIC or the military Installation)?	

THIS FORM IS TO BE COMPLETED BY THE WORKERS' COMPENSATION POINT OF CONTACT/SUPERVISOR

Completed by: _____

Date: _____

Print

Signature

Log of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it.
 Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20

U.S. Department of Labor
 Occupational Safety and Health Administration



You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Form approved OMB no. 1218-0176

Establishment name

City

State

Identify the person		Describe the case			Classify the case			Enter the number of days the injured or ill worker was:		Select the "injury" column or choose one type of illness:								
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness (e.g., 2/10)	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from oxy/acetylene torch)	(G) Death	(H) Days away from work or restriction	(I) Job transfer or restriction	(J) Other recordable cases	(K) Away from work	(L) On job transfer or restriction	(M) Injury	(1) Skin disorder	(2) Respiratory condition	(3) Poisoning	(4) Hearing loss	(5) All other illnesses	(6) All other illnesses
<input type="button" value="Reset"/>			month / day /			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="button" value="Reset"/>			month / day /			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="button" value="Reset"/>			month / day /			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="button" value="Reset"/>			month / day /			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Page totals

Page 1 of 1

Injury (1)

Skin disorder (2)

Respiratory condition (3)

Poisoning (4)

Hearing loss (5)

All other illnesses (6)

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instructions, search existing data sources, gather the data needed, and complete and review the collection of information. Send comments about this burden estimate or any other aspect of this data collection, including suggestions for reducing the burden, to Washington, DC 20503. Do not send the collection of information to this office.

Summary of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it.
 Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the [free Adobe PDF Reader](#).

Year 20

U.S. Department of Labor
 Occupational Safety and Health Administration



Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
(G) _____	(H) _____	(I) _____	(J) _____

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
(K) _____	(L) _____

Injury and Illness Types

Total number of ...	(M)
(1) Injuries	(4) Poisonings
(2) Skin disorders	(5) Hearing loss
(3) Respiratory conditions	(6) All other illnesses

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspect of this data collection, contact US Department of Labor, OSHA Office of Statistical Analysis, Room N-3644, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send this completed form to this office.

Establishment information

Your establishment name _____

Street _____

City _____

State

Zip

Industry description (e.g., *Manufacture of motor truck trailers*) _____

Standard Industrial Classification (SIC), if known (e.g., 3715) _____

OR

North American Industrial Classification (NAICS), if known (e.g., 336212) _____

Employment information (If you don't have these figures, see the Worksheet on the next page to estimate.)

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

Company executive _____

Title _____

Phone _____

Date ____/____/____

Save Input

OSHA's Form 301

Injury and Illness Incident Report

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the [free Adobe PDF Reader](#). In addition, the forms are programmed to auto-calculate as appropriate.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration



Form approved OSHA no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy the printout or insert additional form pages in the PDF, and then use as many as you need.

Information about the employee

- 1) Full name _____
- 2) Street _____
- 3) City _____ State _____ ZIP _____
- 4) Date of birth _____
Month _____ Day _____ Year _____
- 5) Date hired _____
Month _____ Day _____ Year _____
 Male Female

Information about the physician or other health care professional

- 6) Name of physician or other health care professional _____

- 7) If treatment was given away from the worksite, where was it given?
Facility _____
Street _____
City _____ State _____ ZIP _____

- 8) Was employee treated in an emergency room?
 Yes
 No

- 9) Was employee hospitalized overnight as an in-patient?
 Yes
 No

Information about the case

- 10) Case number from the Log _____
(Transfer the case number from the Log after you record the case.)
- 11) Date of injury or illness _____
Month _____ Day _____ Year _____
- 12) Time employee began work _____
 AM PM
- 13) Time of event _____
 AM PM Check if time cannot be determined
- 14) What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "dialy computer key-entry"; _____

- 15) What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." _____

- 16) What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome." _____

- 17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.* _____

- 18) If the employee died, when did death occur? Date of death _____
Month _____ Day _____ Year _____

Completed by	_____
Title	_____
Phone	_____-_____-_____ Month _____ Day _____ Year _____

Page 1 of 1

Save Input

Add a Form Page

Reset

SAMPLE

NOTICE TO EMPLOYEES
Nonappropriated Fund Instrumentalities Act

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



Employer

DEPARTMENT OF THE NAVY

In accordance with the provisions of the Nonappropriated Fund Instrumentalities Act and the Regulations of the U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, this employer has become a self-insurer under the Act and has made appropriate deposit of securities for the payment of workers' compensation benefits to employees and their dependents with respect to injuries and deaths that arise out of and in the course of employment.

WHAT TO DO WHEN INJURED AT WORK

- **NOTIFY YOUR EMPLOYER IMMEDIATELY.** If possible, complete Form LS-201, Notice of Injury, available from your employer. You should give notice of injury to the following person(s):

- **MEDICAL TREATMENT.** Request authority (Form LS-1) from your employer for treatment by the physician you choose. You may not select a physician that is not authorized by the Office of Workers' Compensation Programs to provide medical care under the Act. Your employer has a list of physicians who are not authorized. In an emergency or if unable to contact your employer, go to the nearest hospital or physician, but be sure to let your employer know as soon as possible.
- **DISABILITY.** If you are disabled more than 3 days, contact your employer indicated below for payment of compensation, payable 14 days after your employer has knowledge of injury.
- **IMPORTANT!** The law requires you to give written notice of injury (Form LS-201) to your employer and to the Office of Workers' Compensation Programs within 30 days. Additional time may be allowed for certain hearing loss and occupational disease claims. The address of the Office of Workers' Compensation Programs District Office for this area is:
201 Varick Street Room 740
Post Office Box 249
New York, NY 10014-0249
Fax (646)264-3002

The Address of This Self-Insured Employer is:

DEPARTMENT OF THE NAVY
COMMANDER NAVY INSTALLATIONS COMMAND
FLEET FAMILY READINESS N941
5720 INTEGRITY DR.
MILLINGTON TN 38055-6500

Telephone

(901)874-6716

For Further Assistance and Information:

On request, the Office of Workers' Compensation Programs will explain benefits and proceedings under the above Act. In addition, the Office of Workers' Compensation Programs will inform employees receiving compensation about medical and vocational rehabilitation services, and will assist in obtaining such services.


Authorized Signature for the Employer

6-5-2013
Date Signed

This Notice must be posted and maintained in a conspicuous place in and about the place of business.
(33 U.S.C. 934)

Important Notice

Section 31(a)(1) of the Longshore Act, as extended to the Nonappropriated Fund Instrumentalities 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 by both.

Form LS-242 (NF)
(Rev. 7/86)

GLOSSARY

ADMINISTRATIVE LAW JUDGE- is an official who presides at an administrative trial-type hearing to resolve a dispute between a government agency and someone affected by a decision of that agency.

AGGRAVATION OF PRE-EXISTING CONDITION- If the employment aggravates, accelerates or combines with a disease or infirmity to produce death or disability for which compensation is sought, the employer may be responsible for the entire disability.

AMERICAN MEDICAL ASSOCIATION (AMA) GUIDES- Physicians use these guidelines in determining the extent of disability.

AROSE OUT OF EMPLOYMENT-The injury was caused by the employment. The general rule is that there must be a causal connection between the conditions of work and the accident.

ATTORNEYS- Employees who obtain legal counsel are responsible for attorney fees. The employer is responsible for attorney fees only after a dispute arises and the attorney successfully obtains additional benefits for his client.

AUTHORIZED PHYSICIANS-This includes physicians of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners. Faith healers, Naturopaths and other practitioners of healing acts are not included.

AUTHORIZED TREATMENT- Medical treatment that is authorized by the employer. An employee must request medical care from the employer. When the employee is injured on the job, the employer must furnish the employee with Form LS-1, Request for Examination and/or Treatment, authorizing the employee to seek medical treatment of his/her choice.

AVERAGE WEEKLY WAGE- The weekly wage of the employee at the time of the injury. The average weekly wage is computed on the wages earned in the 52 week period prior to the date of injury.

AWARDS- The level of payments made to an employee according to the disability rating the employee received. Payments are made in installments over a period of time as approved by the DOL.

BENEFITS REVIEW BOARD- See DOL website

CHIROPRACTIC TREATMENT- Chiropractic care is authorized to provide treatment only to correct subluxation shown by X-rays or clinical findings. The reimbursable cost for treatments is limited to manual manipulation of the spine.

CHANGE OF PHYSICIAN- Only the TPA can authorize the change of physician upon the request of the employee. The change is made if the TPA determines that the medical

care which the employee received is inadequate or inappropriate, or that the employee's medical condition requires the attention of a specialist.

CHOICE OF PHYSICIAN- It is the employee's right to freely choose the physician from which they wish to receive initial medical treatment. When the nature of the injury prevents the employee from making a choice, the employer may act in his/ her behalf; however, the employee may later exercise his/her right of free choice.

CLAIMS EXAMINERS- Individuals that are responsible as examiners or adjusters of the workers' compensation claims handled by each of the regional DOL district offices.

COMPENSATION- Benefits based upon the average weekly wage paid by the employer to the employee, in consideration for the work done by the employee. Compensation is based upon the disability. An employee disabled in excess of the three day waiting period receives compensation within 14 business days after the employer has knowledge of the injury. At the time of the first payment, Form LS-206, PAYMENT OF COMPENSATION WITHOUT AWARD is sent to DOL accompanying the payment to the employee. Compensation payments should be made every two weeks.

COMPENSATION BENEFITS- Provided for the following disability categories:

Temporary Total- The inability to earn any wages for a temporary period of time.

Temporary Partial- The partial reduction in wage earning capacity for a temporary period of time.

Permanent Total- The inability to earn any wages until there is an improvement in the medical impairment, or until alternative employment can be found.

Permanent Partial- The compensation paid for loss of, or loss of the use of a scheduled member.

- Once the employee has shown his/her ability to earn wages, the burden shifts to the employer to prove the injured employee can:
 - (1) Perform alternative employment, or
 - (2) Train for employment within the limitations of the medical impairment.

CONTROVERSION—When the employer or insurance carrier denies responsibility to provide benefits. It is required by law to file Form LS-207, Notice of Controversion of Right to Compensation, stating the reasons for the denial. The OWCP will send a copy of that form to the employee with instructions on what to do if the employee disagrees with the denial.

COURSE AND SCOPE OF EMPLOYMENT-An injury arises in the course of employment if it occurs within the time and space boundaries or in the course of an activity whose purpose is related to the employment.

DATE OF INJURY- The date the employee is injured.

DEATH BENEFITS- Death benefits are considered as “new” claims. They are separate and distinct from the right to disability benefits and do not arise until death occurs.

DEPARTMENT OF LABOR (DOL)- The agency authorized by Congress to administer the LHWCA and the NAFI Act.

DISABILITY- The incapacity, because of injury, to earn the wages which the employee was receiving at the time of injury in the same or any other employment.

EMPLOYEE-Individuals who receive wages which are paid to them by the employer as compensation for their work performed for or on behalf of the employer. For purposes of the LHWCA, this excludes workers who do not receive any kind of pay for their services.

EMPLOYER’S LIABILITY FOR COMPENSATION-The employer is only obligated by the NAFI Act to pay benefits as stated under the LHWCA. Workers’ compensation benefits are the only remedy available to the employee. Under the LHWCA the employee cannot seek remedy under a tort claim.

EMPLOYMENT- Under the LHWCA all NAF employees are covered regardless of their employment classifications (full-time, part-time, and flexible). Except for Third country nationals are not covered.

EXTENT OF DISABILITY- Based on the medical information, this requires a determination of how the physical impairment will affect the employee’s ability to earn wages.

FORMAL HEARINGS- The second stage in the appeal process presided by an Administrative Law Judge.

FUNERAL EXPENSES- A total of \$ 3,000 is paid upon receipt of a certified statement of service.

IMPARTIAL MEDICAL EXAMINER (IME) OR AGREED MEDICAL EXAMINATION (AME)- DOL, upon request of an interested party or on their own initiative, can appoint an IME to examine the employee and determine the condition and/or need for further medical care. AME decision is reached between the DOL and the employer to obtain additional medical evidence as a result of an examination from a physician that they mutually agreed upon.

INFORMAL HEARINGS / CONFERENCES-The first stage in the appeal process with regard to the resolution of a dispute. Conferences are informal, minutes are not taken, and only the employee and/or employee’s representative and a representative of the employer and/or the TPA need to be present. Witnesses will not be presented at these conferences. Issues are presented in order to resolve disputes at an informal stage. The DOL

recommendations are advisory and not binding. If not resolved at this level, the case will be referred to Formal Hearing.

INJURY- An accidental injury arising out of and in the course of employment.

INTOXICATION OF EMPLOYEE-There is no coverage under the LHWCA for this type of employee claim. Claim for benefits will be controverted.

LABOR MARKET SURVEY (LMS) -When an employer cannot or will not offer the claimant his former job or light duty work; a LMS must be done to prove employability. The LMS identifies specific jobs available to the claimant within the local community. The employer does not have to find a job for the employee; only proves that there is employment available that he/she can do. The cost of the LMS is borne by the employer.

LAST RESPONSIBLE EMPLOYER- This rule applies exclusively to occupational disease claims. The last employer to expose the employee to the harmful substance or environment is liable.

LIEN (EMPLOYER'S) ON THIRD PARTY RECOVERY- When there is a third party involved in the injury the employer has a right to seek reimbursement for their payment of benefits to an employee who is compensated from a third party. This is permitted under the LHWCA by the employer's filing a lien against any damages awarded by the third party. The employer is reimbursed for any monies spent before the employee is paid.

LITIGATION- The legal process of appeal.

LONGSHORE and HARBOR WORKERS' COMPENSATION ACT (LHWCA)- A law enacted in 1927 that sanctions workers' compensation benefits to maritime workers. The NAFIA enacted in 1952 extended benefits under Longshore to all NAF employees.

LOSS OF WAGE EARNING CAPACITY- When an employee, due to the work related injury is unable to earn the same pre-injury wages.

MEDICAL FEES CHARGED- Must conform to fee schedule with exceptions.

MAXIMUM MEDICAL IMPROVEMENT (MMI) - It refers to the point in an employee's medical treatment beyond which the employee is expected to get any better from further medical care. This is not to imply that the employee's medical treatment is finished.

MEDICAL REPORTS-Reports on the employee's medical condition as it relates to the injury. The reports must follow the AMA guidelines.

MINIMUM AND MAXIMUM WEEKLY COMPENSATION RATES- See TABLE OF COMPENSATION RATES <http://www.dol.gov/owcp/dlhwc/NAWWinfo.htm>

NOTICE- The employee or agent shall give notice to the employer within 10 days after the date of injury or death, or within 30 days after the employee is aware, of a relationship between the injury or death and the employment. In the case of an occupational disease which does not immediately result in disability or death, such notice shall be given within one year after the employee or claimant becomes aware of the relationship between the employment, the disease, and the death or disability.

NOTICE OF HEARINGS- Sent from DOL to advise all parties of hearing.

OCCUPATIONAL DISEASE CLAIMS- Claims which are the result of an employee contracting a disease as a result of exposure to harmful conditions on the job. It does not include the ordinary diseases of life.

NATURE and EXTENT OF THE DISABILITY- Relates to the severity and permanence of the disability caused by work related injury or illness.

PAYMENT OF MEDICAL CARE (INJURY ONLY) -The employer is obligated to provide and pay for medical care for employees injured in accidents arising out of the course and scope of their employment.

PENALTIES- Fine assessed by DOL for knowingly and willfully failing or refusing to file a Form LS-202 within ten (10) days from the injury or from date of knowledge of injury, which causes loss of more than three (3) days of work. Fine will not exceed \$22,587.

PENALTY INTEREST- Interest paid by the employer as a result of late payment.

PRE-EXISTING CONDITION- A medical condition that the employee had prior to the date of injury.

PRODUCT LIABILITY- Incidents or mishaps involving the failure of equipment which results in employee injuries should be reported to the Workers' Compensation POC.

REHABILITATION- A voluntary program. The employer or the employee may refuse to participate. DOL has indicated that an employee must reasonably cooperate with an employer's rehabilitation specialist and, where he/she fails to do so, may affect the determination of the employee's suitability for alternate employment. The employee must show reasonable diligence in attempting to secure some type of alternate employment which the employer could demonstrate was reasonably obtainable and available to the employee.

SCHEDULED AWARD - Schedule Awards are monetary payments for a prescribed number of weeks to federal employees who suffer the permanent total or partial loss of use of those anatomical members, functions or organs of the body. The scheduled award is payable whether the employee is working, on sick or annual leave, receiving retirement benefits or is no longer employed by the federal government. However, an employee

cannot receive a scheduled award while receiving compensation for wage loss at the same time they receive the scheduled award.

SCHEDULED MEMBER – Arms, hand, fingers, legs, foot and toes, eyes, and ears (as related to hearing loss).

SETTLEMENTS- Paid by the employer in final settlement of a disability claim. Settlements may be negotiated by the parties after the employee has reached the point of MMI. There is no requirement to settle a claim.

SOCIAL SECURITY- Social Security disability benefits are offset by the amount of workers' compensation paid.

SPECIAL EXAMINATIONS / INDEPENDENT MEDICAL EXAMINATIONS- The employer may request a special examination of the employee by a physician of its choice at reasonable intervals for which the employee must be available. Failure to attend a special examination may result in suspension of compensation.

TERMINATION OF COMPENSATION BENEFITS TO THE EMPLOYEE-

Can be based but not limited to one of the following reasons:

- The employee returns to work.
- The treating physician finds the employee may return to work.
- The employee fails to attend a special examination to help ascertain the employee's medical condition.
- The employee and employer agree on a settlement with DOL approval.
- Investigation of the claim reveals the claim is not valid.

TERMINATION OF THE EMPLOYEE- Workers' compensation injuries cannot be a cause for termination of employment.

THIRD PARTY ADMINISTRATOR (TPA)- A contractor acting on behalf of the employer. This is not an insurance company. All funds paid by the TPA are NAF dollars advanced by the employer.

UNAUTHORIZED/ SELF-PROCURED MEDICAL BY THE EMPLOYEE- When an employee receives medical care without authorization or the knowledge of the employer and employer has no knowledge of the injury, it is considered self-procured and the sole responsibility of the employee.

UNREASONABLE REFUSAL TO ACCEPT MEDICAL CARE- When an employee refuses to submit either to a special examination requested by the employer or the DOL or surgical intervention which the treating physician considers reasonable, DOL may issue an order suspending further compensation and medical treatment until such time as the employee becomes available for examination or surgical intervention.

VOLUNTEER- A volunteer is a gratuitous worker who performs a task for an employer other than his own. A volunteer is one who neither receives nor expects to receive any

kind of pay for their services. In most instances, volunteers are not covered under the LHWCA; however in most situations, they can be covered.

WAITING PERIOD- No compensation shall be allowed for the three (3) day waiting period commencing on the first day of disability. When the employee is disabled for more than 14 days, the three (3) day waiting period will be paid.

WAIVER OF BENEFITS- The LHWCA prohibits the assignment of the employee's benefits or reduction of their entitlement.

WILLFUL INTENTION BY THE EMPLOYEE TO INJURE OR KILL HIMSELF OR ANOTHER – If it is proven the employee willfully intend to injure or kill himself, they are not entitled to benefits.

WORKERS' COMPENSATION PROGRAM MANAGER- Located at the Morale, Welfare and Recreation Headquarter (CNIC) Millington, TN

**POINTS OF CONTACT
CNIC**

Lynn Hickman lynn.hickman1@navy.mil	DSN 882-6729 Commercial 901-874-6729
Kimberly Seymour kimberly.seymour@navy.mil	DSN 882-4876 Commercial 901-874-4876
Sandy New sandy.new@navy.mil	DSN 882-6716 Commercial 901-874-6716

Headquarters Fax No:
DSN 882-6844
Commercial 901-874-6844

Mailing Addresses:
MWR Headquarters:
(Mail Only)
Department of the Navy
Commander Navy Installations Command N941
5720 Integrity Drive
Millington, TN 38055 - 6530

CCSI:
Bobby Morgan – Claims Manager
Contract Claims Services, Inc.(CCSI)
P.O. Box 541328
Dallas, TX 75354-1328
800.743.2231 ext. 2970

OWCP Offices

U. S. Department of Labor
Office of Workers' Compensation
Division of Longshore and Harbor Workers'
Compensation
201 Varick Street, Room 740
Post Office Box 249
New York, NY 10014-0249
Fax (646) 264-3002

U. S. Department of Labor
Office of Workers' Compensation
Division of Longshore and Harbor Workers'
Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202
Fax (901) 357-4787

Web Site Addresses for Workers' Compensation Information

Department of Labor website Forms www.dol.gov

CCSI website Forms www.ccsholdings.com

APPENDIX

Letter from

Division of Longshore and Harbor Workers' Compensation (DLHWC)

November 14, 2013

INDUSTRY NOTICE No. 144

TO: INSURANCE CARRIERS, SELF-INSURED EMPLOYERS, LONGSHORE EMPLOYERS, LONGSHORE CLAIMANTS, AND OTHER INTERESTED PERSONS

SUBJECT: NEW ADDRESSES FOR CORRESPONDING WITH OWCP, DLHWC ON CASE-SPECIFIC MATTERS EFFECTIVE DECEMBER 2, 2013

To aid in the efficient administration of the Longshore and Harbor Workers' Compensation Act (LHWCA), and its extensions, the Director hereby notifies all parties of important changes that are effective **December 2, 2013**.

1. The New York City DLHWC District Office will assign OWCP case numbers to all new cases, regardless of the location of the injury or the claimant's home address. The New York City office is thus designated as the "Central Case Create" site. Unless a case number has already been assigned, you should submit the following forms to the Central Case Create site at the address listed below for creation of a new case:

LS-201 (Notice of Employee's Injury or Death)

LS-202 (Employer's First Report of Injury or Occupational Illness)

LS-203 (Employee's Claim for Compensation)

LS-262 (Claim for Death Benefits)

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
201 Varick Street, Room 740
Post Office Box 249
New York, NY 10014-0249
FAX (646) 264-3002

2. After a case has been created, all case-specific mail should be sent to the Jacksonville DLHWC District Office at the address listed below for processing even if another district office is administering the claim. The Jacksonville office is thus designated as the "Central Mail Receipt" site. No mail for any case should be sent to any other district office. This applies to all cases in existence on December 2, 2013 and all new cases created after that date.

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202
FAX (904) 357-4787

3. No changes are being made in the other District Offices.

4. Exceptions – The following documents should NOT be submitted to the Central Case Create or Central Mail Receipt sites. Instead, please submit them to the DLHWC Chief – Branch of Financial Management, Insurance and Assessments, Washington, DC at the address specified below.
 - a. Checks. Checks (e.g. those submitted for deposit to the Special Fund or in response to penalties) should no longer be submitted to the District Offices; this is a change from past practice. Instead, please submit all checks to the Branch of Financial Management, which will receive and process them and notify the applicable district office accordingly. If the check is submitted in reference to a specific case, the check should contain the injured worker's name and case number. A copy of the District Office letter or the compensation order should also be submitted with the check.

 - b. Inquiries, forms, and other documents concerning self-insurance authorizations, insurance carrier authorizations, security deposits, and special fund assessments should continue to be addressed to the DLHWC Chief – Branch of Financial Management, Insurance and Assessments.

U. S. Department of Labor
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation
Branch of Financial Management, Insurance and Assessments
200 Constitution Avenue, Room C-4319
Washington, DC 20210

5. Guidelines for Submission of Documents. To facilitate efficient and timely processing, please adhere to the following guidelines when submitting documents.
 - a. Complete all fields on the form legibly, and include the Employer and Carrier Number, if known, on forms submitted to the Case Create Site.
 - b. Submit only one copy of a document or form such as an LS-202, LS-203, LS-206, LS-207, LS-208, 8(f) application or 8(i) application.
 - c. Reference the OWCP File Number on every page of the document.
 - d. Use standard sized paper (8 ½ x 11), with no extending labels or tabs to separate the document parts (such as exhibits or attachments). If a receipt or picture is small, copy it on to or tape it to letter size paper.
 - e. Avoid the use of colored paper and colored ink.

- f. A single document should not reference multiple individuals. In order to protect Personally Identifiable Information (PII), documents cannot be included in the OWCP case file if they reference multiple individuals. Each document should reference only one injured worker.
6. Stakeholders are encouraged to submit routine documents via mail and reserve submission via fax for urgent or time sensitive matters. Unless specifically requested, please avoid the practice of duplicate submissions, e.g. do not submit documents via mail and fax.
7. For specific questions or concerns related to a claim that you wish to convey orally, including questions pertaining to the creation of a case or the receipt of a document, contact the district office administering the claim for assistance. Please do not contact the Central Case Create or Central Mail Receipt site for assistance unless the claim is being managed by the New York or Jacksonville office, respectively.
8. Any general questions concerning this Industry Notice may be directed to the DLHWC Branch of Policy, Regulation and Procedures, Washington, DC. You may also visit our website (<http://www.dol.gov/owcp/dlhwc/>) to find a list of questions and answers related to this change.

Antonio A. Rios
Director, Division of
Longshore and Harbor Workers' Compensation

Updates

Updated August 4, 2016

- Light Duty Advisory form is now the Modified/Alternative Work form

REFERENCES

Department of Labor www.dol.gov

Occupational Health and Safety Administration –Official website <https://www.osha.gov>

CNICINST 5300.2

CCS Holdings Policy & Procedure Manual Revision 5 May 12, 2010