Employer's First Report of Injury or Occupational Illness

(See instructions on reverse - Leave items 1 and 2 blank)

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

OMB No. 1215-0031

1. OWCP No.	2. Carrier's No.	3. Date and Time of Accident Mo. / Day / Yr. / Hour AM PM

4. Name of Injured/Deceased Employee (Type or print - first, M.I., last)

Telephone

5. Employee's Address (No., street, city, state, ZIP code)

6. Injury is Reported Under the Following Act (Mark one)

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

7. Indicate Where Injury Occurred (Longshore Act only) (Mark one)

- A ☐ Aboard Vessel or Over Navigable Waters
- B ☐ Pier/Wharf
- C ☐ Dry Dock
- D ☐ Marine Terminal
- E ☐ Building Way
- F ☐ Marine Railway
- G ☐ Other Adjoining Area

8. Sex ☐ M ☐ F

9. Date of Birth

10. Social Security No. (Required by Law)

11. Did Injury Cause Death? ☐ No ☐ Yes - If yes, skip to 16

12. Did Injury Cause Loss of Time Beyond Day or Shift of Accident? ☐ Yes ☐ No

13. Date and Hour Employee First Lost Time Because of Injury — Mo. Day Yr. Hour AM PM

14. Did Employee Stop Work Immediately? ☐ Yes ☐ No

15. Date and Hour Employee Returned to Work

16. Was Employee Doing Usual Work When Injured/Killed? (If no, explain in Item 26) ☐ Yes ☐ No

17. Did Injury/Death Occur on Employer's Premises? ☐ Yes ☐ No

18. Dept. in Which Employee Normally Works(ed)

19. Occupation

20. Date and Hour Pay Stopped

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.

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.)

(Use additional sheet(s) if required and attach to this report)

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.

28. Has Medical Attention Been Authorized? ☐ Yes ☐ No

29. Enter Date of Authorization

30. Was First Treating Physician Chosen by Employee? ☐ Yes ☐ No

31. Has Insurance Carrier Been Notified? ☐ Yes ☐ No

▶ **Name**	**Address - Enter Number, Street, City, State, ZIP Code** ◀
32. Physician	
33. Hospital	
34. Insurance Carrier **saif**corporation	**Federal Claims Unit, 400 High Street SE Salem, OR 97312-1000**
35. Employer	
36. Nature of Employer's Business	37. Signature of Person Authorized to Sign for Employer
38. Official Title of Person Signing This Report	39. Date of This Report

Form LS-202
Rev. Oct. 1998

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 injur 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 outsidse 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 employeess 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 on a military or Defense Base,

  Give exact place on base where injury happened
  Name of base
  Location of bse - town or country

- If on the Outer Continental Shelf,

  Give drilling site and block number
  Area name (e.g., West Delta Area)
  Federal Lease Number, State Lease Nulmber
  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 make a false statement or mispresentation in this report shall be subject to a civil penalty not to exceed 10,000 for each such failure, refusal, false statement, or mispresentation. [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

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

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