## Employer's Supplementary Report of Accident or Occupational Illness

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

## U.S. Department of Labor Employment Standards Administration

Office of Workers' Compensation Programs



OMB No. 1215-0031

For Office Use

1. OWCP No.

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				1. OWCP No.	
information. (if additional space is needed, determine entitlement to benefits. Person information unless it displays a currently variety.)	s are not required to	respond to this col		2. Carrier's No.	
Name of injured employee (First, middle initial First Name     M.I. Last Name	4. Date of accident (Month, day, year)				
5. Address of injured employee (Number and Strelline 1:	et, City, State, ZIP code) country	6. Name and addres	s of your insuran	ce carrier	
line 2:		city:			
city: st: zip:		st: zip:			
<ol> <li>Initial Period of Disability (Use Inclusive Da a. From (Month, day, year)</li> </ol>	tes for a and b) b. To (Month, day, ye	ar)	C Date returns	ed to work (Month, day, year)	
a. From (month, day, year)	b. 10 (Month, day, ye	c. Date returned to work (Month, day, year)			
If this report covers a period of disability after t a. and b.	he date shown in item 7c	state each subseque	ent period of disa	bility. Use inclusive dates for	
a. From (Month, day, year) b. To (Mor		nth, day, year)	c. Date returned to work (Month, day, year)		
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?		11. Was form LS-1 given to employee when injury was reported to you?			
Yes No		Yes No			
12. Name of employer (Firm Name)		13. Employer's address (Number and Street, City, State, ZIP code)			
		city:			
		st: zip:			
	T			country:	
14. Signature of person authorized to sign for employer	15. Name and official title	15. Name and official title of person signing		16. Date of report (Month, day, year)	
.s. employs:	name:	name:		(, 30,, 500)	
	title:				
	Public Burde	n 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