

**NOTICE TO EMPLOYEES
Defense Base Act**

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

Employer **Choctaw Archiving Enterprise**

This employer is insured to provide compensation benefits (including medical and hospital care) to its employees, or monetary benefits to eligible survivors, in case of work-connected injury, occupational illness or death, in accordance with the provisions of the above law and rules of the Office of Workers' Compensation Programs.

**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):

*Dedra Galleaga, Workers Compensation Manager
2101 West Arkansas Durant, OK 74701
Phone: 580-924-8280 ext. 2730 Fax: 580-924-5764*

- **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 or the insurance company 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:
Richard V. Robilotti, District Director
U.S. Department of Labor ESA/OWCP/DLHWC
201 Varick Street, Room 750
PO Box 249
New York, NY 10014-0249

Insurance Carrier for This Employer:	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.
Name	Fidelity and Casualty Company of New York
Address	180 Maiden Lane, New York, NY 10038
Telephone	1-888-262-0042
Policy Number	DBA 25 727 4735
	Expiration Date of Policy May 25, 2005 - October 01, 2005

Authorized Signature for the Employer

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 Defense Base Act, 33 U.S.C. 93(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.

or Occupational Illness

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

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)	5. Employee's Address (No., street, city, state, ZIP code)
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6. Injury Is Reported Under the Following Act (Mark one) A <input type="checkbox"/> Longshore and Harbor Workers Compensation Act B <input type="checkbox"/> Defense Base Act C <input type="checkbox"/> Nonappropriated Fund Institutionalities Act D <input type="checkbox"/> Outer Continental Shelf Lands Act	Telephone		8. Sex	9. Date of Birth	
	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		<input type="checkbox"/> M <input type="checkbox"/> F		
			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			
		Mo.	Day	Yr.	Hour AM PM

14. Did Employee Stop Work Immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Date and Hour Employee Returned to Work	16. Was Employee Doing Usual Work When Injured/Killed? (If no, explain in item 26) <input type="checkbox"/> Yes <input type="checkbox"/> No
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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
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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.
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23. Wages or Earnings (include overtime, allowances, etc.)	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?
a. Hourly \$		
b. Daily \$		
c. Weekly \$		
d. Yearly \$		

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.
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28. Has Medical Attention Been Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No	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
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▶ Name	Address - Enter Number, Street, City, State, ZIP Code
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32. Physician

33. Hospital

34. Insurance Carrier

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

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 on military or Defense Base,

Give exact place on base where injury happened
Name of base
Location of base - 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 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 make a false statement or misrepresentation in this report shall be subject to a civil penalty not to exceed 10,000 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

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**

Request for Authorization for Treatment

Employment Standards Administration
Office of Workers' Compensation Programs



OMB No. 1215-0066

Part A - Authorization

Instructions to Employer. This side of the form must be completed in full, and authorizes a physician of the employee's choice (*See Item 2 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.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The information collected will be used to supervise the medical care rendered to injured employees and furnishing the information is mandatory (20 CFR 702.419).

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)

3. Employee's name (Last, first, middle)

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

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

10. Telephone (Area code and local number)

11. Date authorized (Month, day, year)

12. Send one copy of your report to:

U.S. Department of Labor
Employment Standards Administration
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

Public Burden Statement

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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**