

Report of Injury Experience of
Self-Insured Employer

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Longshore and Harbor Workers' Compensation

This report is to be used to list all open cases as of the date of the report. The information provided will be used to determine the adequacy of a self-insurer's security deposit. Submission of the information is mandatory (20 CFR 703.310). Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0160

Employer's Name			Employer's Address (Number and street, city, state and ZIP code)				Reporting Period →	List All Open Cases as of the Date of This Report	Date of Report		
Employer's or Carrier's Case Number (a)	OWCP Case Number (b)	Name of Injured Employee (c)	Date of Injury (d)	Nature of Injury (Use abbreviations - frx, spr, etc.) (e)	Amount of Benefits Paid (f)	Estimate of Future Compensation Payments (g)	Estimate of Future Medical Payments (Disability cases only) (h)	Estimate of Total Future Compensation Payments (g + h) (i)	Check Third Party Cases ✓ (j)	Check Fatal Cases ✓ (k)	OWCP Verification (Leave Blank) (l)

Public Burden Statement

We estimate that it will take an average of 60 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.