

1. OWCP No.	2. Carrier's No.	3. Date and Time of Accident Mo. Day Yr. Hour	
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 <input type="checkbox"/> Longshore and Harbor Worker's Compensation Act B <input checked="" type="checkbox"/> Defense Base Act C <input type="checkbox"/> Nonappropriated Fund Instrumentalities Act D <input type="checkbox"/> Outer Continental Shelf Lands Act	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 checked="" type="checkbox"/> M <input type="checkbox"/> F	9. Date of Birth
		10. Social Security No. (See statement on reverse)	
		11. Did Injury Cause Death <input checked="" 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 checked="" type="checkbox"/> No	
		13. Date and Hour Employee First Lost Time Because of Injury Mo. Day Yr. Hour	
14. Did Employee Stop Work Immediately? <input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
17. Did Injury/Death Occur on Employer's Premises? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 x x x x x x x		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.			
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? <input checked="" 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 checked="" type="checkbox"/> No
31. Has Insurance Carrier Been Notified? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		32. Physician Address - Enter Number, Street, City, State, ZIP Code	
33. Hospital		34. Insurance Carrier AIU World Source Division	
35. Employer		8144 Walnut Hill Lane STE #1700 Dallas, Texas 75231	
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