Employment History for Claim Under Energy Employees Occupational Illness Compensation Program Act

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

Disclosure of social security number is voluntary. Failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled. **DO NOT FILL IN SHADED AREAS**	OMB No.: Expires:

EMPLOYEE INFORMATION

Print Name Last First M.I.	Social Security Number
Former Name (i.e. maiden name/legal name change/other) Last First M.I.	Employee Number(if known)

In the following section, list the complete employment history of the employee named above in chronological order. Begin with the most recent period of employment. If you require additional space to explain or clarify any point, attach a supplemental statement to this form.

EMPLOYER 1

Dates of Employment	Start Date / /	End Date / /

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness. (N/A for none)

Was a dosimetry badge worn while employed?

☐ YES Dosimetry Badge Number _____ ☐ NO

EMPLOYER 2

Dates of Employment	Start Date / /	End Date / /

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness. (N/A for none)

Was a dosimetry badge worn while employed?

☐ YES Dosimetry Badge Number _____ ☐ NO

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May 2001

EMPLOYER 3

Dates of Employment	Start Date / /	End Date / /

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness. (N/A for none)

Was a dosimetry badge worn while employed?

☐ YES Dosimetry Badge Number _____ ☐ NO

EMPLOYER 4

Dates of Employment	Start Date / /	End Date / /

Employer (Name/Address/Location where work was performed)

Position Title & Description of Work Performed

Describe all factor(s) believed to have contributed to the development of the claimed illness. (N/A for none)

Was a dosimetry badge worn while employed?

☐ YES Dosimetry Badge Number _____ ☐ NO

DECLARATION OF PERSON COMPLETING FORM

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Print Name _____

Street Address _____

City/State/ Zip _____ Phone _____

I affirm that the employment history provided on this form is accurate and true.

Signature _____ Date _____

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INSTRUCTIONS FOR COMPLETING FORM EE-3

This form is used to gather information regarding an Energy employees work history. If additional space is required, attach a supplemental statement to this form. **YOU MAY USE AS MANY COPIES OF THE EE-3 FORM AS NECESSARY IN ORDER TO PROVIDE A COMPLETE EMPLOYMENT HISTORY FOR THE EMPLOYEE.**

Dates of Employment

Beginning with the most recent period of employment and working backward, list the the period of employment for each job held.

Employer (Name/Address/Location where work was performed)

Identify the name, address or any other type of descriptive information regarding the employer for each period claimed. Contractor and subcontractors should list the name of the company that held contract with the United States government. In addition, identify the location where employment activities were conducted. This can include the name of the facility, site, laboratory, building, mine etc.

Position Title & Description of Work Performed

Identify the job title and the type of work activities performed during the listed period of employment.

Describe All Factors(s) Believed to have Contributed to the Development of the Claimed Illness.

Provide a brief statement explaining the date and circumstance of all factors believed to have contributed to the claimed illness.

Was a Dosimetry Badge Worn While Employed?

Indicate whether or not the employer required a dosimetry badge to be worn. If yes, provide the dosimetry badge identification number.

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (P.L. 106-398) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collections actions required or permitted by the Debt Collection Act. (6) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the EEOICPA.

PUBLIC BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 1 hour per response, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, sent them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim to this address. Completed claims are to be submitted to the appropriate regional District Office of Workers' Compensation Programs. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.