U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number:

CA1031-O-D

File Number:
Date of Injury:
Employee:
Dep(s):

Dear :

To help us reach a decision regarding a claim for compensation filed by , please furnish the information requested below. This information is required to obtain or retain a benefit (5 U.S.C. 8101).

1. State your relationship to employee (that is, wife, husband, natural parent or guardian of dependent(s) named above, or parent of employee).
_____

2. State the amount of money the employee regularly contributes to your support or to the support of the dependent(s) named above. State how often the contributions are made--weekly, monthly, etc. If contributions are not made at regular intervals or in the form of money, please explain.
_____
_____

3. Approximate date such contributions were first made: _____

4. If you are a natural parent or legal guardian of the dependent(s) named above, give the age and relationship to the employee of each dependent. _____
_____

5. If you are a parent of the employee, state the source and amount of all your other income. If none, so state. _____
_____

File Number:
Employee:

I certify that each and every statement made above is true to the best of my knowledge. I further understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

_____ _____
Signature Date

Sincerely,

NAME OF SIGNER
TITLE

NOTICE TO RECIPIENT

Public reporting burden for this collection of information estimated to vary from 10 to 20 minutes per response with an average of 15 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the US Department of Labor, OWCP, Room S3229, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.