U.S. Postal Service

REQUEST - OWCP CLAIM STATUS

OWCP File No.

Section A

To:

OFFICE OF WORKERS COMPENSATION PROGRAMS
UNITED STATES DEPARTMENT OF LABOR

_____

_____

Instructions

A. **Postmaster:** Enter File No. and complete Section A. Check request boxes in Section B as needed (1-5). Forward to OWCP District Office in duplicate.

B. **OWCP Office:** The employee below has filed a claim with you. Please help us determine this claimant's status by completing Section B as checked (1-5). Sign, date and return copy to Requester.

Requester

Name: _____

Address: _____

_____

Date:

Claimant

Name: _____

Work Address: _____

_____

Date Injured:

Section B

This is restricted information and is used only for official Postal Service purposes.

1. ☐ Claim for Benefits is:

- ☐ a. Accepted *(Date)* _____
- ☐ b. Rejected *(Date)* _____
- ☐ c. Pending

2. ☐ Employee is Currently Receiving Compensation:

- ☐ Yes *(Complete Item 3.)*
- ☐ No

3. ☐ Type/Amount of Payment:

- ☐ a. Temporary Total Disability of $_____ per _____.
- ☐ b. Permanent Total Disability of $_____ per _____.
- ☐ c. Loss of Wage Earning Capacity of $_____ per _____.
- ☐ d. Scheduled Award of $_____ per _____. Terminates *(Date)*_____

4. ☐ Last Medical Examination *(Date)*: _____*(Attach Copy)*

5. ☐ Other *(Specify)*: _____

_____

_____

Signature and Title *(OWCP Officer)*	Date

PS Form **2573,** June 1991