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than the same day that f	irst payment is made. A copy should ND to their attorney (if represented).	1. OWCP No.	2. CARRIER'S No.		
3. Name of injured person (First, m	iddle, last - please print or type)				
4. Address of injured person (Num	ber, street, city, state and ZIP code)				
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## Payment Of Compensation Without Award

## U.S. Department of Labor Office of Workers' Compensation Programs



(Longshore and Harbor Workers' Compensation Act, as extended)

## OMB No. 1240-0043

NOTE: This Notice is to be filed with the District Director not later	· · · · · · · · · · · · · · · · · · ·	FOR OFFICE USE			
NOTE: This Notice is to be filed with the District Director not later than the same day that first payment is made. A copy sho be sent to the payee(s) AND to their attorney (if represented		1. OWCP No.	2. CARR		
3. Name of injured person (First, middle, last - please print or type)					
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Average weekly wage \$		naximum rate is being paid)	ΓY	es No	
<ol><li>Compensation will be paid from - Enter month, day, year.</li></ol>		or DBA cases only, is the emp ured person's salary?	loyer con		
ntil notice is given that payment has been stopped or suspended 9b. If so, are these salary continuation payments				ents being made in	
0. Date of first payment (Month, day, year.)	day, year.) lieu of comper		Γ Ye	es No	
11. Has medical care and treatment been provided by a physician or hospit (Mark appropriate box)	al chos	en by the injured person?			
12. Name and address of employer (Name, number, street, city, state, ZIP code	and cou	untry)			
		United	l States		
13. Name and address of insurance carrier and/or claim administrator(Name,	numbe	r, street, city, state, ZIP code a	nd countr	y)	
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14. Authorized signature					
15. Type or print title and name of person whose signature appears in item 14 Ph			Г 16.	Date signed(mm-dd-yyyy)	
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