



This report is authorized by the Black Lung Benefits Act (30 U.S.C. 901 et. seq.). While completion of this form is voluntary, we need your cooperation so that we may determine eligibility or payments due on a claim for benefits under the Act. We would appreciate your prompt completion and return of this form. An envelope requiring no postage is enclosed for your use. (Please see the Privacy Act statement before completing this form.)

OMB No. 1240-0031  
Expires: 06/30/2026

Name and Address of School (include branch or campus and division)  _____  _____  _____  _____	<b>TWO FILING OPTIONS:</b> 1. To file electronically, submit completed form to the COAL Mine Portal: <a href="https://coalmine.dol.gov">https://coalmine.dol.gov</a> 2. To file by mail, send completed form to: US Department of Labor OWCP/DCMWC PO Box 8307 London, KY 40742-8307 For Further Information call TOLL FREE: 1-800-347-2502
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<input type="checkbox"/> Attn: Registrar	Telephone: _____	Date: _____
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Name of Miner on whose earnings claim is based (Last, First, Middle Initial)  _____	DOL's Case ID Number:  _____
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<b>Student</b>	
Name (Last, First, Middle Initial)  _____	Student's Date of Birth (mo, day, yr.)  _____

Student identification Number used by School (If none, enter "None".)  
  
 \_\_\_\_\_

Student's Expected Graduation Date \_\_\_\_\_

**Complete All Items Below Giving Information Only For Period Indicated.**

Attendance  
 From (mo., day, yr.) \_\_\_\_\_ To (mo., day, yr.) \_\_\_\_\_  Present

**Certification By School Official**

1. Is the above student now in "Full-Time Attendance" According to the School's Standards and Practices? (For evening students use the same standards applicable to day students.)  Yes  No

2. Was the above student in "Full-Time Attendance" According to the School's Standards and Practices during entire period entered above?  
 Yes  No (If "No", answer 3.)

3. If item 2 is answered "No" Please enter the beginning and ending dates (up to the present) of the student's <b>Full-Time Attendance</b> . If none, enter "None". (If more space is needed, use space on the reverse.)	From (mo., day, yr.) _____  To (mo., day, yr.) _____
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4. Check the type of School:  Junior College, College or University  High School  
 Technical, Trade or Vocational  Other (Specify)

5. (To be completed by all schools except junior colleges, colleges, or universities) Enter the total clock hours per week the student is (was) scheduled to attend; show any variations in scheduled attendance on the reverse:	Total hours per week _____
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**Knowing that a person who willfully makes any false or misleading statement or representation to obtain benefits or payments under the Black Lung Benefits Act shall be guilty of a misdemeanor under 30 USC 941 and, on conviction, subject to a civil money penalty or imprisonment for up to one year, or both, I certify that according to this institution's records the information given above is true.**

**School Official**

Phone Number:	E-mail Address	Date
Signature of School Official	Title	

**Privacy Act Statement**

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to this application, on claimants and their immediate families; (2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to other government agencies, coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability, contractors providing automated data processing services to the Department of Labor; and representatives of the parties to the claim; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of the claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim; (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits; and (9) this information is included in a System of Records, DOL/OWCP-2 published at 81 Federal Register 25765, 25858 (April 29, 2016) or as updated and republished.

**Notice**

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the OWCP claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments of changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

**Public Burden Statement**

Public reporting burden for this collection of information is estimated to average 10 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.