Attorney Fee Approval Request

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

You must use this form to request the District Director's approval of an attorney fee under Section 28 of the Longshore and Harbor Workers' Compensation Act and its extensions. You must serve a copy on the relevant employer/carrier(s) and their representatives. You must support the application with a complete statement of the extent and character of the necessary work done, described with particularity as to the professional status, the normal billing rate, and the hours spent by each person in representing the claimant. See 20 CFR 702.132.

OMB No.: 1240-0058
Expires: 04/30/2029

Submit form to the OWCP/DLHWC Central Mail Receipt site at the following address:
U.S. Department of Labor, Office of Workers' Compensation Programs
DLHWC
400 West Bay Street, Suite 63A, Box 28
Jacksonville, FL 32202

Or upload directly to the case file using the Secure Electronic Access Portal (SEAPortal)

Access the SEAPortal directly at:
https://seaportal.dol.gov/portal/

If you have not already filed a service waiver, you should promptly submit an LS-801 or LS-802 form(s) to receive the Order via email. The form(s) must be uploaded in SEAPortal separately.

1. Date of Accident/Illness:	2. Carrier's No.	3. OWCP No.

4. Name of Injured Worker and Claimant *if other than injured worker*

5. Name of Firm, Attorney(s), Address and Phone# of Person(s) Seeking Fees:

6a. Amount requested for Fees:	6b. Amount Requested for Costs:
6c. Hourly Rate(s) for Attorney(s):	6d. Hourly Rate for Paralegal(s)/Law Clerk(s):
6e. Total Hours Claimed for each Attorney:	6f. Total hours claimed for each Paralegal/Law Clerk:

7. Have the parties reached agreement on the amount of the fee? ☐ Yes *Proceed to 8* ☐ No *Proceed to 9*

8a. The agreement reached is that payment be made by: *(select one but not required if no agreement reached)* ☐ Employer/Carrier ☐ Claimant

8b. To Payee:	Amount for Fees:	Amount for Costs:

9a. If the fee is not agreed to, fees are sought under Section *(check all that apply):* ☐ 28(a) ☐ 28(b) ☐ 28(c)

9b. Describe efforts made to resolve the fee:

I certify that all of the information above and in the attachments is accurate. I also certify that I have served the form and attachments on all other parties and their representatives.

10. Print Name	11. Sign	12. Date

Print Reset

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public burden for this collection of information is estimated to average 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. Use of this form is required to request the Office of Workers' Compensation Longshore Program's approval of an attorney fee under 33 U.S.C. 928 and 20 C.F.R. 702.132. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, NW, Room S-3524, Washington, D.C. 20210 and reference the OMB Control Number. Note: Please do not return the completed LS-4 to this address.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

PRIVACY ACT STATEMENT

The following information is provided in accordance with the Privacy Act of 1974, as amended, 5 USC 552a. (1) This collection of information is authorized under the Longshore and Harbor Workers' Compensation Act (LHWCA) and its extensions. (2) The information will be used to adjudicate attorney fee requests before the Office of Workers' Compensation Longshore Program. (3) Completion of this form is required to request approval of an attorney fee by the Office of Workers' Compensation Longshore Program. (4) Disclosures of this information may be made to: the claimant and his or her representative(s); the employer, the insurance carrier or other entity that secured the employer's compensation liability, and their representative(s); the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, authorized or required to render decisions on claims or other matters arising in connection with a claim; Federal, state and local agencies to determine whether benefits are being and have been paid properly and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law; and other individuals, their representatives, and government agencies enforcing a legal obligation for alimony or child support. (5) Failure to provide the information on this form may delay processing of the attorney fee request, the payment of attorney fees, or may result in an unfavorable decision or reduced level of fees. (6) This information is included in two Systems of Records, DOL/OWCP-3, 4, published at 81 Federal Register 25765, 25859-61 (April 29, 2016), or as updated and republished.