OWCP File Number _____

AUTHORIZATION OF REPRESENTATION

This will confirm that _____, (union representative) and the designated agents are authorized to represent me in all respects, arising out of the facts and circumstances of my claim against the U.S. Department of Labor (DOL), the Office of Workers' Compensation Programs (OWCP), and their subsidiaries, agents and/or employees.

Please be advised that American Federation of Government Employees, AFL-CIO, Local No. 1273 is my authorized Representative to represent me before all U.S. Governmental Agencies and/or their subsidiaries, Physicians and Medical Facilities, and any other person(s) and/or entity(s) for my above referenced claim in every aspect.

I request that all notices and copies of any/all other communications directed to me, including, but not limited to notices to me for physicians appointments, requests for additional evidence and/or all mandatory forms for which I should fill out with the advice of counsel, be simultaneously and contemporaneously sent to my authorized representative at the following address (20 CFR 10.144).

American Federation of Government
Employees, AFL-CIO, Local No. 1273
500 W. Fort. St., Mailstop L1273
Boise, ID 83702-4501
Phone: (208) 422-1033
Fax: (208) 422-1239
Email: OWCP@afge1273.org

Please note that any Federal Agency personnel/employees or any of their subsidiary employees are prohibited from making communication or contact to my client or any of his treating physicians or treating physician's offices regarding his OWCP claim.

This authorization acts as a revocation of all other authorizations which I may have signed prior to the effective date of this document, and as a result, any other authorization in your possession is hereby immediately revoked and canceled.

A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL.

_____ _____
Employee Signature Date

_____
Employee's Printed Name