

**FEDERAL EMPLOYEE INJURY COMPENSATION BASIC TRAINING  
ENROLLMENT FORM**

Request Date: \_\_\_\_\_ Training Dates: from \_\_\_\_\_ to \_\_\_\_\_

Attendee: Last Name \_\_\_\_\_, First Name \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position Title: \_\_\_\_\_

Employing Agency: \_\_\_\_\_

Confirm Attendee is a U.S. Federal Government Employee: Yes \_\_\_\_\_

Injury compensation duties/responsibilities are (briefly):

\_\_\_\_\_

Attendee has been performing the aforementioned duties for \_\_\_\_\_ (months/years)

Supervisor's Signature: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Supervisor's Title: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:**

- Complete all information requested above. Print clearly. Federal employee enrollment only.
- Forward signed completed form to [OWCP-DFEC-WDC-TRAINING-REQUESTS@dol.gov](mailto:OWCP-DFEC-WDC-TRAINING-REQUESTS@dol.gov).
- Once the enrollment form is submitted, you will only be notified if the class is full and cannot accept anymore enrollment.
- Attendee will receive an email about how to connect to the training few days before the first day of class.