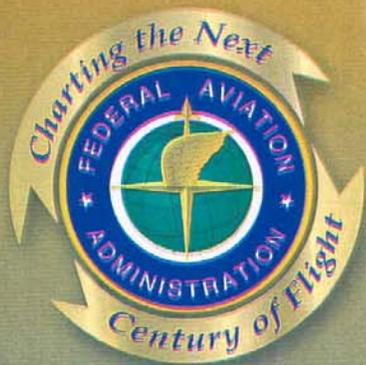


*Federal Aviation
Administration*

**SUPERVISOR'S
MANUAL FOR
WORKERS'
COMPENSATION**



FIRST EDITION

Prepared by Federal Aviation Administration
Office of Employee Relations
and Benefits (AHL-100)

*800 Independence Avenue, SW
Washington, DC 20591*





U.S. Department
of Transportation
**Federal Aviation
Administration**

Office of Human Resource Management

800 Independence Ave., SW.
Washington, DC 20591

Federal Aviation Administration Workers'
Compensation Program:

I am proud to introduce the Federal Aviation Administration (FAA) Supervisor's Manual for the Workers' Compensation Program. This Guide is meant to be a useful and informative tool to help you fulfill your responsibilities in this very important program. As a supervisor, you serve a vital role in managing your injured employees workers' compensation claims and we feel this guide will provide you with the information you need to perform that role.

As part of our commitment to create a model workers' compensation program, the Office of Labor and Employee Relations has formed a task force to manage claims from Southern Region and Headquarters. This task force will ensure that every injured employee receives their benefits as expeditiously as possible and is returned to work as soon as they are medically capable. I encourage those of you in the Southern Region and Headquarters to contact our team at (202) 267-3871 or (202) 267-9020 with any questions you have in managing your injured employees' claims. For those of you outside of Southern Region and Headquarters, please contact your servicing Human Resources Management Division (HRMD) for guidance. All claims from the other Regions continue to be managed by their servicing HRMD.

We encourage you to keep this reference close at hand. We hope that you will find it to be an invaluable reference.

Sincerely,

A handwritten signature in black ink, appearing to read "Raymond B. Thoman".

Raymond B. Thoman
Deputy Assistant Administrator for Labor
& Employee Relations

Table of Contents

Section 1: Overview

- 1.01 [Objective](#)
- 1.02 [Introduction](#)
- 1.03 [General Information](#)
- 1.04 [Conditions of Coverage](#)
- 1.05 [Benefits under the FECA](#)
 - Medical Benefits
 - Wage Loss Compensation

Section 2: Types of Injuries, Claim Forms, and Continuation-of-Pay

- [2.01](#) Traumatic Injury
- [2.02](#) CA-1 Form
- [2.03](#) Continuation-of-Pay
- [2.04](#) Controversion of COP
- [2.05](#) Termination of COP
- [2.06](#) Occupational Disease
- [2.07](#) CA-2 Form
- [2.08](#) Recurrence
- [2.09](#) CA-2a Form
- [2.10](#) CA-7 Form (Claim for Compensation)
- [2.11](#) Leave Buy Back
- [2.12](#) Challenging the Validity of a Claim

Section 3: Managing Disability Claims

- [3.01](#) Goals of Proactive Case Management
- [3.02](#) Value of Return to Work
- [3.03](#) Steps in Return to Work Process

Section 4: Exhibits

- [4.01](#) List of OWCP Forms
- [4.02](#) List of Checklists, Definitions, and References
- [4.03](#) Training Presentation

Section 1: Overview

1.01 Objective

The purpose of this guide is to help you understand the worker's compensation process and your role in this system. This guide is meant to help you educate yourself what actions you can or should take with regard to worker's compensation claims.

Everyone has a right to file a claim but not every claim will be accepted. We need to assist injured employees and reduce the growing costs of this program. By helping injured employees file claims (which we are required by law to do), controverting claims when necessary, monitoring claimants' recoveries, and returning employees back to work as soon as possible, we will be successful in improving service, diminishing abuse, and containing costs. This guide will help you know what you can do.

1.02 Introduction

This manual is designed to offer a step by step approach to handling workers' compensation forms and issues for supervisory personnel at the FAA. This manual will inform supervisory personnel of the different categories of injuries, types of claim forms, actions required and the time frame limitations under the FECA. In addition, supervisory personnel will be versed on issues regarding Continuation of Pay (COP), Controversion of [CA-1 forms](#), recurrence of disability, and returning recovered and recovering employees to work at light duty. This manual provides an overview outlining FECA policy and procedures and FAA workers' compensation program directives.

1.03 General Information About Workers' Compensation

Program Costs

As of June 30, 2002, 4,300 FAA claimants receive workers' compensation payments, costing the lines of business over \$88 million. Claimants receive full cost of living adjustments annually, and compensation for wage loss is paid at either 75% or 66 2/3% of an employee's salary, tax-free. Additional payments may also be made for medical expenses, death benefits, scheduled awards, and vocational rehabilitation. Payments are made to employees, former employees, and in some instances, surviving family members.

Program Operation

The Federal Employees Compensation Act (FECA) is administered by the Department of Labor (DOL) Office of Workers' Compensation Programs (OWCP) and provides monetary compensation, medical care and assistance, travel to and from medical care, vocational rehabilitation, funeral expenses, survivor benefits and retention rights to Federal employees injured in the performance of duty. FAA pays the costs associated with FECA benefits, but OWCP makes all eligibility and disability decisions.

Sole Remedy

The benefits provided under OWCP are the only compensation benefits available to FAA employees and their beneficiaries for work-related injuries, illnesses or death. Employees and surviving dependents cannot sue the United States or its agencies for damages for any injury, illness or death coverage by OWCP.

Appeals

The FAA may not appeal OWCP actions but it may provide evidence and comments to OWCP during the claim adjudication process and during appeals made by the claimant. Claimants may appeal case decisions directly to OWCP. There are three methods for reviewing a formal decision of the OWCP: reconsideration by the district office; a hearing before an OWCP hearing

representative; and appeal to the Employees' Compensation Appeals Board (ECAB).

Penalties for Misuse

No employer or other person may require an employee or other claimant to enter into any agreement, either before or after an injury or death, to waive his or her right to claim compensation under the FECA. A number of statutory provisions make it a crime to file a false or fraudulent claim or statement or to wrongfully impede a FECA claim. When a beneficiary either pleads guilty to or is found guilty of defrauding the Federal government in connection with a claim for benefits, the beneficiary's entitlement to further compensation benefits will terminate effective the date either the guilty plea is accepted or a verdict of guilty is returned after trial.

Administrative Matters

The DOL, through its district offices, has sole responsibility for administering the program and for making determinations on claims. DOL assigns a number to each claim that should be used for all correspondence regarding the case.

Burden of Proof

The employee is responsible for establishing the essential elements of the claim. These are listed below under "Conditions of Coverage".

Questionable Claims

If the validity of a new claim is questionable, the supervisor should investigate the circumstances and report them to OWCP with supporting factual evidence. Any such supporting evidence should be submitted with the notice of traumatic injury or death, or within 30 calendar days from the date the notice of occupational disease or death is received from the claimant. Do not delay submitting the notice of traumatic injury, notice of occupational disease or notice of death while gathering additional evidence. Immediately bring the form to the Human Resources Management Division (HRMD) Workers Compensation Specialist along with a statement that additional evidence is forthcoming. See sections [2.04](#) and [2.12](#) for further information on challenging claims. For employees already on OWCP's rolls, the employer may ascertain the events surrounding the extent of disability where it appears that an employee who claims total disability may be performing other work, or may be engaging in activities that would indicate less than total disability. However, the provisions of the Privacy Act apply to any endeavor by the employer to ascertain the facts of the case.

Decision and Notification

OWCP will notify the employee in writing of the status of his/her claim and any other subsequent decisions made on the claim. Agencies do not have appeal rights once a case has been accepted. If a claim is denied, DOL will notify the employee of his/her appeal routes with DOL. FAA employees may not appeal OWCP decisions to FAA since the agency has no jurisdiction over the OWCP program.

Information and Records

Individual case files are protected under the Privacy Act, and only the injured employee, his/her officially designated representative, and agency personnel may routinely have access to these files. Any documentation regarding an injured employee's compensation claim that is housed at the employing agency is the property of DOL. Employers may establish procedures for an injured employee or beneficiary to obtain documents, however, these rules must comply with OWCP's regulations, and no employer may correct or amend records pertaining to OWCP claims. In the FAA, all records pertaining to OWCP claims are maintained in the servicing Human Resources Management Division (HRMD).

Penalties Under the FECA

- Waiver of compensation –The regulations at 20 CFR Section 10.15 state that no employer or other person may require an employee or other claimant to enter into any

agreement, either before or after an injury or death, to waive his or her right to claim compensation under the FECA. No waiver of compensation rights shall be valid.

- Criminal penalties in connection with a claim under the FECA: the regulations at 20 CFR Section 10.16 make it a crime to file false or fraudulent claim or statement with the government in connection with a claim under the FECA, or to wrongfully impede a FECA claim. Included among these provisions are sections 287, 1001, 1920, and 1922 of title 18, United States Code. Enforcement of these and other criminal provisions that may apply to claims under the FECA are within the jurisdiction of the DOJ.
- Under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. 3801-12 administrative proceedings may be initiated to impose civil penalties and assessments against persons who make, submit, or present, or cause to be made, submitted or presented, false, fictitious or fraudulent claims or written statements to OWCP in connection with a claim under the FECA. The DOL's regulations implementing the PFCRA are found at 29 CFR part 22.
- When a beneficiary either pleads guilty to or is found guilty on either federal or state criminal charges of defrauding the Federal government in connection with a claim for benefits, the beneficiary's entitlement to any further compensation benefits will terminate effective the date either the guilty plea is accepted or a verdict of guilty is returned after trial, for any injury occurring on or before such guilty plea or verdict. Termination of entitlement under this section is not affected by any subsequent change in or recurrence of the beneficiary's medical condition.

1.04 Conditions of Coverage

Each claim for compensation must meet certain requirements before it can be accepted. The requirements are addressed somewhat differently according to the type of claim (Traumatic, Occupational, Death); however, they are always considered in the same order. This section will discuss these " 5 Basic Requirements" as well as 3 statutory prohibitions to payment of compensation.

TIME

All cases must first satisfy the statutory time requirements of the FECA. (Injuries or deaths that occurred before September 7, 1974 are covered under different provisions. The agency should contact DOL with any questions regarding timeliness for these kinds of claims.)

For injuries or deaths on or after September 7, 1974 the law provides that a claim for compensation must be filed within 3 years, of the injury or death. Compensation for disability or death, including medical care in disability cases, may not be allowed if the claim is not filed within that time frame with the following exceptions:

- The immediate supervisor had actual knowledge of the injury or death within 30 days. The knowledge must be such to put the immediate supervisor reasonably on notice of an on-the-job injury or death.
- Written notice of injury or death as specified in section 8119 of the Federal Employees Compensation Act is given within 30 days.
- In cases of latent disability, the time for filing claim does not begin to run until the employee has a compensable disability and is aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship of the compensable disability to his/her employment.

- The time limitations do not begin to run for a minor (death beneficiary) until he/she reaches age 21 or has a legal representative appointed.
- Time limitations do not run against an incompetent individual while he is incompetent and has no legal representative.
- Time limitations do not begin to run against any individual whose failure to comply is excused by the Secretary of Labor on the ground that such notice could not be given because of exceptional circumstances (for example being held prisoner of war).

CIVIL EMPLOYEE

If the claim is timely filed, it is then determined if the claimant was an "employee" within the meaning of the law. The FECA covers all civilian Federal employees except for non-appropriated fund employees. In addition, special legislation extends coverage to Peace Corps and Vista volunteers; Federal petit or grand jurors; volunteer members of the Civil Air Patrol; Reserve Officer Training Corps (ROTC); Job Corps and Youth Conservation Corps enrollees; and non-Federal law enforcement officers under certain circumstances involving crimes against the United States.

Temporary employees are covered on the same basis as permanent employees. Contract employees, volunteers, and loaned employees are covered under some circumstances; such determination must be made on a case-by-case basis once a claim is filed. Federal employees who are not citizens or residents of the United States or Canada are covered subject to special provisions governing pay rates and computation of benefit payments.

FACT OF INJURY

Once the issues of time and civil employee have been resolved affirmatively, it must be established that the employee in fact sustained an injury or disease. Two factors are involved in this determination:

- Occurrence of Event: Did the employee actually experience the accident, event or employment factor that is alleged to have occurred? This is resolved on the basis of factual evidence, including statements from the employee, the supervisor, and any witnesses. An injury need not be witnessed in order to be compensable. A supervisor who believes, however, that the employee's testimony is contrary to the facts should supply pertinent information to support this belief.
- Existence of a Medical Condition: Did the accident or employment factor result in an injury or disease? This is determined on the basis of the attending physician's statement that a medical condition is present that could be related to the incident, though the medical report need not relate the condition to the incident. Simple exposure, for instance to a contagious condition or duty environment, does not constitute an injury.

PERFORMANCE OF DUTY

If the first three criteria have been accepted, it must be determined whether the employee was in the performance of duty (POD) when the injury occurred. An injury is generally said to have occurred in the performance of duty if the injury arose:

- during the course of employment, AND
- out of the employment.

Arising during the course of employment means that the injury occurred while the employee

was carrying out the duties for which he or she was hired. Arising out of the employment means that the incident was directly related to some aspects or circumstances of the employment, not to personal non-work circumstances. The following are examples of typical performance of duty issues:

Industrial Premises Rule

An employee who is injured on agency premises during work hours has the protection of FECA unless engaged in an activity that removes him/her from the scope of employment. Coverage includes injuries that occur while the employee was performing assigned duties or engaging in an activity, which was reasonably associated with employment. Such activities include use of facilities for the employee's comfort, health, and convenience as well as eating meals and snacks provided on the premises. The premises include areas immediately outside the building, such as steps or sidewalks, if these are Federally owned or maintained. The supervisor should document an injury occurring in such an area by submitting a diagram showing where it happened.

Outside Working Hours

Coverage is extended to employees who are on the premises for a reasonable time before or after working hours. Usually a half hour before or after work is considered a reasonable amount of time. Coverage is not extended, however, to employees who are visiting the premises for non-work related reasons. The supervisor should verify the time of the injury and provide any information in its possession about the employee's purpose in being on the premises at the time of the injury.

Parking Facilities

The agency's premises include the parking facilities that it owns, controls or manages. An employee will usually be covered under FECA if injured on such parking facilities. The supervisor should submit a statement indicating whether it owns or leases the parking lot, and if the latter, the name and address of the owner (this information may be needed for purposes of developing the third-party aspect of the claim). If the parking lot is not immediately adjacent to the building, the supervisor should also supply a diagram showing where the injury took place in relation to the parking lot and the building.

Off Premises Injuries

Coverage is extended to workers such as letter carriers, chauffeurs, and messengers who perform a service away from the employer's premises. It is also extended to workers who are sent on errands or special missions and workers who perform services from their homes. Workers working on telecommuting arrangements are only afforded coverage if injured while performing official duties in the designated site where work is performed. If the employee steps away from this specific location to perform a personal errand (such as the kitchen, garage, etc.) coverage is not afforded.

To and From Work

Employees do not have the protection of the FECA when injured en route between work and home, except where the agency furnishes transportation to and from work, the employee is required to travel during a curfew or emergency, the employee is on stand-by duty and is called in to work, or the employee is required to use his/her vehicle during the work day. Such claims should be accompanied by a description of the circumstances.

Lunch Hour

Injuries that occur during lunch hour off the premises are not ordinarily covered unless the employee is in travel status or is performing regular duties off premises. Though an individual is not actually performing work duties, he/she would be considered in the performance of duty if eating lunch on the premises, having a coffee break or going to the restroom, because these activities are incidental to employment.

Travel Status

Employees in travel status are covered 24 hours a day for all reasonable incidents of their temporary duty. Thus an employee injured on a sightseeing trip in the city to which he or she is assigned would not be covered, while an employee injured while taking a shower at the hotel would be covered. All claims for injuries occurring during travel status should be accompanied by a copy of the travel authorization.

Recreation

An employee is covered while engaged in formal recreation for which he/she is paid or required to perform as a part of training or assigned duties. Injuries that occur during informal recreation on the agency premises are also covered. Under other circumstances, the agency must supply what benefit it derived from the employee's participation, the extent to which the agency sponsored or directed the activity, and whether the employee's participation was mandatory or optional.

Horseplay

An employee who is injured during horseplay is covered if the activity was one, which could reasonably be expected where a group of workers are closely associated for extended periods of time. In this kind of case, it must be determined whether the specific activity was a reasonable incident of the employment or whether it was an isolated event which could not reasonably have been expected to result from close association.

Assault

An injury or death caused by the assault of another person may be covered if it is established that the assault arose out of an activity directly related to the work or work environment. Coverage may also be extended if the injury arose out of a personal matter having no connection with the employment if it was materially and substantially aggravated by the work association. The supervisor should submit copies of reports of any internal or external investigation as well as witness statements from parties with knowledge of the incident.

Emergencies

Coverage is extended to employees who momentarily step outside the sphere of employment to assist in an emergency, such as to extinguish a fire.

Violation of a Safety Rule or Engaged in a Prohibited Activity

Injuries sustained when an employee violates a safety rule are considered to be in the performance of duty, arising out of employment if:

- The rule is not stringently enforced
- No warnings were previously given to the employee for this behavior (documented)
- The employee was unintentionally negligent

Injuries are not considered in the performance of duty and not arising out of employment if:

- The rule is stringently enforced
- The employee had frequent documented warnings
- The employee was intentionally or deliberately negligent (refusing to wear required safety equipment). Deliberate negligence must be proven.

CAUSAL RELATIONSHIP

After the four factors described above have been considered, causal relationship between the condition claimed and the injury or exposure sustained is examined. Unlike fact of injury, which involves the determination that a medical condition is present, causal relationship involves establishment of a connection between the injury and the condition found. This factor is based entirely on medical evidence provided by physicians who have examined and treated the employee. Opinions of the employee, supervisor or witness are not considered, nor is general medical information contained in published articles.

Kinds of Causal Relationship

An injury or disease may be related to employment factors in any one of four ways.

- **Direct Causation:** This term refers to situations where the injury or factors of employment result in the condition claimed through a natural, unbroken sequence.
- **Aggravation:** If a pre-existing condition is worsened, either temporarily or permanently, by a work related injury, that condition is said to be aggravated.
 - **Temporary Aggravation** involves a limited period of medical treatment and/or disability, after which the employee returns to his or her previous medical status. Compensation is payable only for the period of aggravation established by the medical evidence, and not for any disability caused by the underlying condition.
 - **Permanent Aggravation** occurs when a condition will persist indefinitely due to the effects of the work-related injury or when a condition is materially worsened by a factor of employment such that it will not return to the pre-injury state.
- **Acceleration:** A work related injury or disease may hasten the development of an underlying condition, and the ordinary course of the disease does not account for the speed with which the conditions develop.
- **Precipitation:** This term refers to a latent condition, which would not have manifested itself on this occasion but for the employment. For example, an employee's latent tuberculosis may be precipitated by work-related exposure.

STATUTORY EXCLUSIONS

Benefits are not payable if an injury is sustained as a result of:

- Willful misconduct
- Intoxication
- Intent to injure self or others

1.05 Benefits under the FECA

MEDICAL BENEFITS

The FECA authorizes medical services for treatment of any condition, which is causally related to factors of federal employment.

- No limit is imposed on the amount of medical expenses
- No limit is imposed on the length of time these expenses will be covered for an accepted condition
- Fees are expected to be reasonable and customary for the geographic location
- A need for the services must be established

Federal employees are entitled to all services, appliances, and supplies prescribed or recommended by qualified physicians which, in the opinion of OWCP, are likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation.

Important Notations on Medical Treatment

- Chiropractic treatment is only authorized under the following two circumstances:
- Manual manipulation of the spine to correct a subluxation as shown to exist on x-rays
- Limited course of physical therapy if prescribed by the authorized attending physician
 - To guarantee that OWCP will pay the provider, some forms of medical treatment should be approved by OWCP in advance:
 - Non-emergency surgery
 - Medical equipment for home use, i.e. hospital beds, traction apparatus, chairs
 - Orthopedic appliances and shoes
 - Courses of physical therapy
 - Hearing aids and lip reading services
 - The services of hearing and seeing eye dogs
 - Memberships in health clubs
- An employee who wishes to change his treating physician must get prior approval to do so from DOL.

COMPENSATION FOR WAGE LOSS

Computation of Benefit Amounts

Compensation based on loss of wages is payable after continuation of pay has expired or when pay loss begins as the result of continuing injury related disability. Compensation benefits are generally paid on a weekly (daily roll) or four-weekly (periodic roll) basis. Checks may be sent to the beneficiary or directly to a financial institution designated by the beneficiary. Compensation benefit amounts are based on a percentage of the injured employee's salary. An employee's compensation rate is based as follows:

- 75% of the employee's basic salary -- if the employee has dependents
- 66 2/3% of the employee's basic salary -- if there are no dependents

WORKERS' COMPENSATION BENEFITS ARE TAX FREE!!!!

Pay Rate

The pay rate or salary used to compute compensation benefits is the greater of the pay in effect on the following dates:

- Date of Injury
- Date that disability begins
- Date of recurrence

Cost of Living Increases

Each March 1, the increase in the cost of living for the preceding calendar year is determined. If the beneficiary has been in receipt of compensation for at least one year before March 1, a cost-of-living increase is applied to the benefit.

Types of Compensation Payments

- Temporary Total Disability: Monetary payments made when an employee claims compensation because he is in a LWOP status as a result of his work-related injury.
- Leave Buy Back: Compensation entitlement for leave repurchase in those instances where an employee used his/her own sick or annual leave while disabled by an accepted work-related injury.
- Schedule Award: Compensation paid for specified periods of time for the permanent loss, or loss of use, of certain member and functions. This compensation is computed on a proportional basis related to the percentage of impairment and the employees' pay rate.
- Loss of Wage Earning Capacity: If the employee is returned to work at a lower paying job compensation is paid based on the loss of wage earning capacity.
- Disfigurement: Where the employee suffers injury to the face, head or neck, and disfigurement results, the FECA provides for an award of compensation. Such awards are considered only for seriously disfiguring scars and deformities.
- Attendants Allowance: If an injury is so severe that the employee is unable to care for his/her physical needs, such as feeding, bathing, or dressing, an attendant's allowance is payable. All attendant's allowances are paid as medical expenses. A home health aide, licensed practical nurse, or similarly trained individual is to provide the necessary services.
- Death Benefits: The survivors of a federal employee whose death is work-related are entitled to benefits in the form of compensation payments, funeral expenses, and transportation expenses for the remains if necessary. If an employee in receipt of OWCP benefits dies and the death is not related to the employment injury, survivors are not entitled to further OWCP benefits but should instead file for an OPM survivor's benefit.

Section 2: Types of Injuries, Claim Forms, and Continuation-of-Pay

2.01 Traumatic Injury

A traumatic injury is a wound or other condition caused by external forces occurring during a specific event or incident, or that occur within one work shift.

2.02 The CA-1 Form

This form is used to file a claim for a traumatic injury.

- The front of the CA-1 must be completed by the employee. In cases, where the injured employee is incapacitated and unable to complete this form, the form may be completed by someone on their behalf, i.e. the supervisor or witness.
- The reverse side of the form is to be completed by the supervisor

- The employee must complete this form within 30 days from the date of injury in order to be eligible for Continuation of Pay (COP).
- The claimant has 3 years from the date of injury to file a claim for traumatic injury.
- The agency is required to submit completed claims to the DOL in a timely fashion. DOL has mandated that all claim forms must be *received in the District Office* within 14 calendar days of the employee's signature on item 15 of the CA-1. To ensure timely submission to DOL, the supervisor must bring the completed claim form to the servicing HRMD immediately.

Other applicable forms that may be provided with the CA-1:

- [CA-16](#): Authorization for Examination and/or Treatment should be distributed along with the CA-16 information sheet (see section 4.00 for instructions on issuing CA-16)
- [HCFA 1500](#): This is a billing form for the health care provider
- [CA-17](#): Duty Status Report: this form is completed by both the physician and the supervisor

2.03 Continuation of Pay

Continuation of Pay (COP) is the continuation of regular pay by the FAA to an injured employee. There is no charge to sick leave or annual leave. The injured employee is entitled up to 45 calendar days of COP when:

- Form CA-1 is filed within thirty days from the date of injury
- The injured employee presents medical evidence to support disability within 10 calendar days.
- COP is never payable in occupational disease claims (see [section 2.06](#))

Counting COP days

- If the employee is injured before the work shift or official hours begin and there is immediate time loss, the first day of COP begins on the date of injury.
- If the employee is injured after official hours begin and there is immediate time loss, the day following the date of injury is the first day of COP. The date of injury is charged to administrative leave.
- If the employee has no immediate time loss, the first day of COP must be utilized within 45 days of the date of injury.

Additional Notes about COP:

- COP days do not need to be used consecutively. If an employee uses some COP days within the 45 days following the injury and then returns to work, he/she is entitled to a period of 45 days from the first return to work to utilize the remaining COP balance. This is true only if the additional time loss is incurred because of the injury and is certified by the treating physician.
- If the employee becomes disabled again more than 45 days following the first return to work, he/she is not entitled to COP. At this point, the employee may file a CA-7 claim form (see section [2.11](#)) with the Department of Labor or elect to use sick or annual leave.
- COP may be used for Doctors visits and therapy appointments that are related to the accepted injury.

2.04 Controversion of COP

Controversion of COP is the option of the employee's supervisor or the HRMD WCS and is used to dispute the injured workers' eligibility for COP entitlement. Under the FECA there are nine (9) reasons to controvert COP. They are as follows:

- The disability is the result of an occupational disease or illness (not a traumatic injury).
- The employee comes within the exclusions of 5 U.S.C.8101(1)(B) or (E), which refers to persons serving without pay, and to persons appointed to the staff of a former President.
- The employee is neither a citizen nor a resident of the United States or Canada.
- The injury occurred off the agency's premises and the employee was not engaged in official
- "off premises" duties.
- The injury resulted from the employees' willful misconduct; the employee's intention to bring about his/her own death or that of another person, or; the employee's intoxication by alcohol or illegal drugs, which includes any controlled substance obtained and used without proper medical prescription.
- The injury was not reported on a form approved by OWCP ([Form CA-1](#)) within 30 days from the date of injury.
- Work stoppage first occurred more than 45 days after the injury.
- The employee first reported the injury after employment with the FAA was terminated.
- The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, work-study program, or other group covered by special legislation.

The agency may dispute the validity of the claim for any reason. However, if one of the nine reasons cited above is not relevant the COP should continue pending adjudication of the claim by OWCP. See [section 2.13](#) for information on challenging claims of questionable veracity.

2.05 Termination of COP

Continuation of Pay (COP) may be terminated for the following reasons:

- Medical evidence is not submitted within 10 calendar days from the date that the employee claims COP or the disability begins or recurs, whichever is later;
- The employee is no longer disabled, i.e. medical evidence from the attending physician states that the worker is released to regular work;
- A partially disabled employee returns to full time light or limited duty with no pay loss;
- The employee refuses to accept a suitable light or limited duty position when offered, or
- The 45 days of COP have expired.

NOTE: An employee who is scheduled to be separated and who reports a traumatic injury on or before the date of separation is entitled to COP up to the date of separation. If the employee remains disabled following the date of separation he/she may be eligible for wage loss compensation thereafter.

2.06 Occupational Disease

An Occupational Disease is a condition caused by the work environment over a period longer than one workday or shift. It may result from a systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes or other continuing conditions of work. COP should *never* be paid.

2.07 The CA-2 Form

This form is used to file a claim for a occupational disease.

- The front of the CA-2 is completed by the employee. In cases of incapacity, the form maybe completed by someone acting on the employee's behalf, i.e. supervisor or witness.
- The reverse side of the form is completed by the supervisor.
- The employee has three years either from the date of exposure, the date when he/she realized that the medical condition was related to the job exposure, or the date last exposed to the work factor to file a claim for occupational disease.
- The employee should be provided with the applicable Occupational Disease checklist when they request a [form CA-2](#). The supervisor must also respond to the checklist questions.
- The agency is required to submit completed claims to DOL in a timely fashion. DOL has mandated that all claim forms must be received in the District Office within 14 calendar days of the employee's signature on item 18 of the form CA -2. To ensure timely submission to DOL, the supervisor must bring the completed claim form to the servicing HRMD immediately.
- Never issue form CA-16 to an employee who is filing form CA-2, unless advised otherwise by DOL.

Other applicable forms that may be provided with the CA-2:

- [HCFA 1500](#): This is a billing form for the Health Care Provider
- [CA-17](#): Duty Status Report: This form is completed by both the physician and the supervisor.
- [Occupational Disease Checklist](#)

2.08 Recurrence

A recurrence is a spontaneous onset of symptoms and/or disability related to the original injury, with no intervening injury or illness. If a new incident or exposure is responsible for the symptoms, even if to the same body part, this is considered a new injury and a CA-1 or CA-2 should be filed.

2.09 The CA-2a Form

This form is filed when there is a:

- Recurrence of medical condition: The documented need for further medical treatment after release from treatment for the accepted condition when there is no accompanying work stoppage. The claimant has the burden of establishing the relationship of this need to the original injury.
- Recurrence of disability: To include certain kinds of work stoppages that occur after an employee has returned to work after a period of disability. The claimant has the additional burden of establishing that not only the condition but also the current disability is related to the original injury. This burden exists whether the claimant returns to regular or to

light duty.

Completion of the [CA-2a](#):

- Part A of the [form CA-2a](#) must be completed by the employee. In cases of incapacity, the form may be completed by someone acting on the employee's behalf, i.e. supervisor or witness.
- Part B (the reverse side) of the form is completed by the supervisor or injury compensation personnel
- Part C should be completed by the claimant and submitted as part of the evidence required to support the claimed recurrence.

Other applicable forms that may be provided with the CA-2a:

- [HCFA 1500](#): This is a billing form for the health care provider
- [CA-17](#): Duty Status Report; this form is completed by both the physician and the supervisor.

2.10 Claim For Compensation; Form CA-7

This form is filed in the following circumstances:

- Wage loss compensation: The injured employee is disabled for work as a result of his/her accepted work related condition (and is either not entitled to COP or has exhausted all COP entitlement).
- Schedule Award: The injury has resulted in a permanent impairment involving total or partial loss, or loss of use, of scheduled parts of the body.
- Leave buy back: The injured employee used sick or annual leave for days when he/she was disabled for work as a result of an accepted condition (the employee must also submit forms CA7a and CA-7b)

Completion of [Form CA-7](#)

- Sections 1 through 7 of [form CA-7](#) is completed by the injured employee, or someone acting on his/her behalf.
- Sections 8 through 15 of form CA-7 must be completed by the supervisor
- The form should be completed after 30 days of COP has elapsed or in the case of occupational disease or injury as soon as the employee enters a leave without pay status
- The agency is required to submit completed claims to DOL in a timely fashion. DOL has mandated that all claim forms must be received in the District Office within 14 calendar days of the employees' signature in Section 7 of the form. To ensure timely submission to DOL, the supervisor must bring the completed claim form to the servicing HRMD immediately.

Other applicable forms that may be provided with the CA-7:

- [CA-20](#): This form is completed by the attending physician and is used to certify disability for work as a result of the accepted condition
- [CA-17](#): This form is submitted to the attending physician to determine work capacity
- [CA-7a](#) and form [CA-7b](#): are completed by injury compensation and payroll personnel in the case of leave buy back claims

2.11 Leave Buy Back

If an employee has elected to use sick or annual leave and the claim is subsequently approved, the employee may choose to have this leave restored through the leave buy back (LBB) process. The employee may buy back some, all, or none of the leave used.

In addition to the CA-7, the employee must file a [CA-7a Time Analysis Form](#) and a [CA-7b Worksheet/Certification and Election Form](#). To have leave restored, the employee must provide medical evidence related to the period requested for buy back and OWCP must approve the time as compensable. OWCP will then pay a percent of the employee's leave to the FAA (the portion they would have paid in compensation) and the employee must pay the remaining balance to the FAA. Compensatory time used may not be repurchased; and, donated annual leave repurchased by the leave recipient shall be restored to the leave donor.

All LBB claims must be filed within one year of the date the leave was used or the claim was accepted, whichever is later.

2.12 Challenging the Validity of a Claim

The FAA may dispute any claim until it is adjudicated by OWCP. Any claim for workers' compensation may be disputed if the supervisor, or other agency official, believes that the circumstances surrounding the claim are of a questionable nature, or the claim does not meet one of the five conditions of coverage by OWCP described previously under section 1.04. Since the agency does not have appeal rights once a claim has been adjudicated by OWCP, it is vital that all relevant information be gathered and submitted to DOL *prior to* adjudication of the claim.

- When you bring the [CA-1/CA-2](#) claim form to the servicing HRMD, advise the WCS that you plan to challenge the claim. Together you can put together a package which spells out the reasons you feel the claim is questionable.
- Whenever you submit information to challenge a claim, provide facts rather than opinions or conjecture.
- The facts should be supported by objective evidence such as witness statements, pictures, accident investigations, time sheets, differing versions of the incident, evidence that the injury occurred outside work, or any other objective means.
- The evidence must show how the claim is deficient in meeting at least one of the five required Conditions of Coverage, or is excluded from coverage by statute (e.g., the employee was engaging in willful misconduct, was intoxicated, or intended to harm himself or others).

Section 3: Managing Disability Cases

3.01 Goals of Proactive Case Management

- Ensure injured employees receive entitled benefits as expeditiously as possible.
- To return the injured employee to medically suitable, productive employment as soon as possible based on probative medical evidence.

3.02 Value of Return to Work

There is immense economic and psychological value in returning an injured employee to some type of work. It is important to let our employees know up front that they will be returning to work

and that they have a valuable contribution to make. By being proactive about returning employees to work we can avoid having to replace injured employees and train new ones, thus saving a great deal of administrative and supervisory time and cost to the agency.

The nature of the injury and the medical evidence presented by the employee's physician will determine when and how an employee will return to work. Most medical restrictions deal with limiting the number of hours an employee can work each day or limiting the employee to specific work functions. Ideally, if the employee is unable to return to full duty, the employee's position should be modified to accommodate the medical restrictions and allow the employee to return to work in a temporary alternate work assignment until able to return to full duties. Contact your servicing HRMD if you have conduct or performance issues not directly related to the injury. It is not acceptable to allow an employee who is capable of working to remain out of work and in receipt of OWCP benefits for conduct or other performance issues.

3.03 Steps in Return To Work Process

Maintain Regular Contact with Disabled Employees

Contact your disabled employees on a regular basis (weekly or bi-weekly, depending on the circumstances of the case). The importance of this step cannot be overstated. Employees need to know that they remain valued employees of the agency while they recover and that they are expected to return as soon as possible. Remind disabled workers that they remain an employee of the agency and continue to be bound by all FAA and OWCP rules and regulations; check on their condition and inquire if you can provide any assistance in their recovery; advise employee that you are willing to accommodate them in any way that their physician states is medically necessary; and request frequent updated medical documentation spelling out the employee's work capacity. The employee is required to remain in contact with the agency during their recovery, and hearing from their supervisor regularly keeps them in the proper mindset to continue to recover and return to the productive workforce. This regular contact is one of the most important steps you can take to help your disabled workers expedite their recovery and return to work.

Develop a Pre-Identified Pool of Temporary Duties

It is helpful to have a number of pre-identified alternate work tasks available throughout your division for injured workers. You might want to develop a set of 6 to 8 return-to-work task options for your organization or identify organization-wide tasks or projects that can be accomplished by injured workers. Identify the tasks and classify them by importance, required skills, physical demands, availability and duration (ongoing, periodic/seasonal or one-time only, available across all shifts or offered in less than 8-hour or full shift increments). Draft descriptions of each of these tasks and have them ready to provide to physicians. You can solicit the help of the HRMD Workers' Compensation Specialist and/or Staffing Specialist to do this.

Obtain Probative Medical Documentation

The employee's supervisor and the HRMD Workers' Compensation Specialist are entitled to obtain detailed medical documentation of the employee's current condition for the purpose of returning the employee to work. This may require the HRMD WCS contacting the OWCP office, the OWCP nurse, or even the physician directly. However, you may only contact the employee's physician in writing. You might also want to solicit assistance from the Office of Aviation Medicine. [Form CA-17](#) may be sent to the physician at any time to determine an employee's work capacity. Plan on sending this form to the attending physician regularly.

The medical documentation should include:

- Firm Diagnosis of the injury

- Current course of treatment (physical or occupational rehabilitation, medications, number of office visits, etc.)
- Prognosis for recovery (when the person is expected to recover)
- Current work capabilities

A good detailed example of what type information to request can be found in the instructions section of the [CA-2 Form](#).

Share Medical Documentation with Key Players

Provide current medical documentation to the HRMD Workers' Compensation Specialist, and Office of Aviation Medicine, if necessary. However, keep in mind that all records are protected under the provisions of the Privacy Act, and should be handled and shared accordingly.

Plan the Employee's Return to Work

In consultation with the HRMD Workers' Compensation Specialist, a Staffing and/or Employee Relations Specialist, the OWCP nurse or claims examiner, and Office of Aviation Medicine, review the current medical information and develop a plan of action for assisting the employee back to work as soon as possible. This may include creating temporary alternate duties that match the employee's current work capabilities until the employee is fully recovered and able to resume full duties. OWCP notifies claimants of their return-to-work requirements based on the medical documentation. However, we can plan an employee's return to work as soon as we have medical documentation that indicates the person can work.

Develop Temporary Alternate Duties

If an employee is unable to return to regular work, first look at the regular work setting for the possibility of a temporary modification for a few weeks/months.

- What's not getting done in your work area?
- What special projects are currently on your "To Do" list?
- Are there training issues in the division?
- If you had eight hours of free labor to be used outside of the regular workload, how could it be used?
- What administrative functions of your job could be delegated to an injured employee?
- Are there production or administration areas that need straightening, organization, sorting, labeling?
- What quality control issues need to be addressed in the department?
- What are the challenges in the department?
- Are there bottlenecks or logjams?
- What are the issues and how can they be addressed?

Make the Return to Work Offer:

In collaboration with the servicing HRMD, contact the employee with the offer about returning to work. The offer should be in writing (sent by certified mail) and should describe:

- The proposed job duties
- The physical requirements of the job
- The location of the job
- The date the job is available
- The date by which a response to the offer is necessary
- The pay rate or salary of the job offered (if different from the employee's current salary)
- The work schedule

The offer should include medical documentation describing the employee's work capabilities. The letter should also cite the requirement for return to work. Send a copy of the letter to the OWCP claims examiner and document all actions taken.

Response to Offer

The employee is required to accept any reasonable offer of limited duty. Whether the job offered is accepted or refused, you must notify the HRMD Workers' Compensation Specialist of the employee's response so the OWCP claims examiner can be advised and wage loss compensation benefits can be terminated or reduced. If the employee refuses to accept the work offered, any traumatic injury leave (COP) being received should be terminated as of the date the employee refused the offer, or after five workdays from the date of the offer, whichever is earlier. OWCP will then determine any continued entitlement to compensation based on the medical reports and the job offered to the employee.

Return to Full Duty/Permanent Reassignment

After the period of limited duty outlined by the physician expires, the employee should return to full duty, unless otherwise indicated by the medical documentation. The medical documentation must state in a detailed narrative report the diagnosis, prognosis, and approximate date the employee can resume full duty work. If the injury prevents the employee from returning to full duty, the employee may be reassigned to another position at the same grade and same pay, to a lower grade position and lower salary, or to another facility in the employee's commuting area. In addition, we can subsidize the person working in another government agency or even private sector job through the OWCP vocational rehabilitation program known as Assisted Reemployment. For more information contact your HRMD Workers' Compensation Specialist.

Section 4: Exhibits

4.01 OWCP Forms

- Exhibit 1 [CA-1](#): Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
- Exhibit 2 [CA-2](#): Notice of Occupational Disease and Claim for Compensation
- Exhibit 3 [CA-2A](#): Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
- Exhibit 4 [CA-5](#): Claim for Compensation by Widow, Widower and/or Children
- Exhibit 5 [CA-6](#): Official Superior's Report of Employee's Death
- Exhibit 6 [CA-7](#): Claim for Compensation on Account of Traumatic Injury or Occupational Disease
- Exhibit 7 [CA-7a](#): Time Analysis Form
- Exhibit 8 [CA-7b](#): Leave Buy-Back (LBB) Worksheet/Certification and Election
- Exhibit 9 [CA-16](#): Authorization for Examination and/or Treatment
- Exhibit 10 [CA-17](#): Duty Status Report
- Exhibit 11 [CA-20](#): Attending Physician's Report (attached to form CA-7, also available separately)
- Exhibit 12 [CA-35 a-h](#): Occupational Disease Checklists

Exhibit 13 [HCFA 1500](#): Billing form for Health Care Providers

4.02 Checklists, Definitions and References

[Exhibit 14](#) Supervisor Responsibilities

[Exhibit 15](#) HRMD Workers' Compensation Specialist Responsibilities

[Exhibit 16](#) Employee Responsibilities

[Exhibit 17](#) Definitions

[Exhibit 18](#) References

4.03 Training Presentation

[Exhibit 19](#) PowerPoint Presentation

Exhibit 1

Federal Employee's Notice of
Traumatic Injury and Claim for
Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data					
1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step		
7. Employee's home mailing address (Include city, state, and ZIP code)				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
---	--	--	---------------------------

13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation code	
	b. Type code	c. Source code
	OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- b. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- a. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed	
Address	City	State	ZIP Code

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
ZIP Code	

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
--	--

22. Date of injury Mo. Day Yr.	23. Date notice received Mo. Day Yr.	24. Date stopped work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
--------------------------------	--------------------------------------	---

25. Date pay stopped Mo. Day Yr.	26. Date 45 day period began Mo. Day Yr.	27. Date returned to work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
----------------------------------	--	---

28. Was employee injured in performance of duty? Yes No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)	31. Name and address of third party (Include city, state, and ZIP code)
--	---

32. Name and address of physician first providing medical care (Include city, state, ZIP code)	33. First date medical care received Mo. Day Yr.
--	--

	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.	37. Pay rate when employee stopped work \$ Per
--	--

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor _____ Date _____

Supervisor's Title _____ Office phone _____

39. Filing instructions No lost time and no medical expense: Place this form in employee's medical folder (SF-86-D)
 No lost time, medical expense incurred or expected: forward this form to OWCP
 Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g., if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason in detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

- a) The disability was not caused by a traumatic injury.
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is not a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 45 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continues the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.
 - (2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.
 - (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.
 - (4) Vocational rehabilitation and related services where directed by OWCP.
 - (5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.
- An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.
- For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

Exhibit 2

**Notice of Occupational Disease
and Claim for Compensation**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a. b. and c.

Employee Data

1. Name of employee (Last, First, Middle)			2. Social Security Number		
3. Date of birth MO. Day Yr.	4. Sex	5. Home telephone ()	6. Grade as of date of last exposure Level Step		
7. Employee's home mailing address (Include city, state, and ZIP code)			6. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other		

Claim Information

9. Employee's occupation		a. Occupation code
10. Location (address) where you worked when disease or illness occurred (Include city, State, and ZIP code)		II. Date you first became aware of disease or illness MO. Day Yr.
12. Date you first realized the disease or illness was caused or aggravated by your employment MO. Day Yr.	13. Explain the relationship to your employment, and why you came to this realization	

14. Nature of disease or illness	OWCP Use - NOI Code	
	b. Type code	c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** _____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and ZIP Code)	OWCP Agency Code
	OSHA Site Code
ZIP Code	

20. Employee's duty station (Street address and ZIP Code) ZIP Code

21. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	22. Regular work schedule <input type="checkbox"/> Sun. <input checked="" type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
--	---

23. Name and address of physician first providing medical care (include city, state, ZIP code)	24. First date medical care received Day Yr.
	25. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

26. Date employee first reported condition to supervisor Mo. Day Yr.	27. Date and hour employee stopped work Mo. Day Yr. Time:	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
---	--	---

28. Date and hour employee's pay stopped Mo. Day Yr. Time	29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time a.m. p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage CSRS FERS Other, (Specify)

33. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," go to Item 34.	34. Name and address of third party (include city, state, and ZIP code)
--	---

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this Claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor Date

Supervisor's Title Office phone

INSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

- a) A detailed history of the disease or illness from the date it started.
- b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.
- c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.
- d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)
- e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

- a) Dates of examination or treatment.
- b) History given to the physician by the employee.
- c) Detailed description of the physician's findings.
- d) Results of x-rays, laboratory tests, etc.
- e) Diagnosis.
- f) Clinical course of treatment.
- g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

- a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.
- b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.
- c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.
- d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)
- e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below.**14. Nature of the disease or illness**

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

20. Employee's duty station, street address and ZIP code

The street address and zip code of the establishment where the employee actually works.

24. First date medical care received

The date of the first visit to the physician listed in item 23.

33. Was the injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

19. Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

23. Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32. Employee's Retirement Coverage.

Indicate which retirement system the employee is covered under.

Employing Agency - Required Codes**Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code**

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

- (1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.
- (2) Payment of compensation for total or partial wage loss.
- (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.
- (4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) The information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) The information may also be given to Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Exhibit 3

Notice of Recurrence

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



Employee: Complete Part A below.

Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

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

OMB No. 1215-0167
 Expires: 05-31-05

Part A - Employee

1. Name of employee (Last, First, Middle)		2. Social Security Number	3. OWCP file number for original injury
---	--	---------------------------	---

4. Date of birth Mo. Day Yr.	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Home telephone ()
---------------------------------	---	--------------------------

7. Home mailing address (include city, state, and ZIP code)	8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other
---	---

9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)	10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
--	--

11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work after recurrence (mo., day, year)	14. Date and Hour pay stopped after recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
---	--	--	---	---

<input type="checkbox"/> Medical Treatment Only <input type="checkbox"/> Time Loss From Work	17. Date of first medical treatment following recurrence (mo., day, year)	18. Name and address of treating physician
---	---	--

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) Yes No

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the Federal Employees' Compensation Act (FECA), or who knowingly accepts compensation to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.
 I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.
 I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee	24. Date (mo., day, year)
---------------------------	---------------------------

Part B - Federal Employing Agency

25. Name and address of reporting office (include city, state, and ZIP Code)	OWCP Agency Code
ZIP Code	OSHA Site Code

26. Employee's duty station (street address and ZIP Code)	27. Date of first return to FULL- TIME REGULAR duty following original injury
ZIP Code	Mo. Day Yr.

28. Regular work hours From: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	29. Regular work days <input type="checkbox"/> Sun. <input type="checkbox"/> Tues. <input type="checkbox"/> Thurs. <input type="checkbox"/> Mon. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
--	--

30. Date of injury Mo. Day Yr.	31. Date of recurrence Mo. Day Yr.	32. Date stopped work after recurrence Mo. Day Yr.	Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
--------------------------------	------------------------------------	--	--

33. Date pay stopped after recurrence Mo. Day Yr.	34. Dates COP paid for recurrence From Mo. Day Yr. To Mo. Day Yr.	35. Date returned to work after recurrence Mo. Day Yr.	Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
---	---	--	--

36. Did the employee receive medical care at an agency facility due to the recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please attach all relevant medical records.	37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? Yes No If so, provide full details.

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.

40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

A supervisor or compensation specialist who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)	42. Title	43. Work phone ()	44. Date (mo., day, year)
--	-----------	--------------------	---------------------------

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

\$ _____ per _____

5. Do you claim compensation for lost wages? Yes No

If so, for what period? _____ through _____.

6. Have you received any pay during the period claimed? Yes No

If so, how much and from what source? _____

Section 8101, et seq., Title 5 to the U.S. Code authorizes collection of this information. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate, data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee

8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work-related injury. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. The physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original injury. Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations.
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless: the claimant is still receiving continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting neither wage-loss compensation nor payment of medical expenses. In these instances, file the form in the Employee Medical Folder.
- If COP is being paid, obtain medical evidence using Form CA-17, "Duty Status Report", as often as circumstances indicate.
- For a recurrence less than 90 days after the employee's return to work following the original injury, you may authorize required medical care using Form CA-16. For a recurrence more than 90 days after the employee's return to work, OWCP must authorize further medical care.
- For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 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. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Exhibit 4

Claim for Compensation by Widow,
Widower, and/or Children

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



OMB No. 1215-0155
Expires: 04-30-2004

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number _____ _____ _____ _____ _____ _____	
6. Name and address of employing agency (Include ZIP Code)		7. Nature of injury which caused death			

Claim of Surviving Husband or Wife (Items 8 through 13)

8. Name and address (Include ZIP Code)	9. Your Date of Birth (Mo., day, year)	10. Date of Marriage to Employee (Mo., day, year)
11. Were you living with the employee at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Were you ever married to anyone other than the employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Was employee ever married to anyone other than yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children)

Name	Relationship	Date of Birth	Address (Include ZIP Code)

14a. List all of employee's children from prior marriages who may be entitled to compensation:

Name	Relationship	Date of Birth	Address (Include ZIP Code)

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include ZIP Code)

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include ZIP Code)

17. If application has been made for any other Federal Retirement or Disability Law because of employee's death, give:

Retirement System: CSRS FERS SSA Other

Claim Number for each claim:

a. _____

b. _____

Date each benefit began:

a. _____

b. _____

Amount of each benefit paid per month: \$

a. _____

b. _____

18. If application has been made for Veterans Administration (VA) benefits because of employee's death, give:

Service number: _____ VA Claim number: _____

Address of VA office where claim is filed: _____

19. If a claim has been made against a third party because of employee's death, give:

Amount of recovery: \$ _____

Name and address of third party: _____

20. Total burial expense \$ _____	21. Amount of burial expense paid or payable by VA \$ _____	22. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid: \$ _____
--------------------------------------	--	--

I hereby certify that each and every statement made above is true to the best of my knowledge.

23. Signature of person filing claim	24. Address (Include ZIP Code)	25. Date (Mo., day, year)
--------------------------------------	--------------------------------	---------------------------

Attending Physician's Report

1. Name of deceased employee (Last, first, middle) 2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you? 4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided. 6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Yes No
Give the medical reasons for your opinion, unless causal relationship is obvious.

10. Was a biopsy or an autopsy performed? Yes No
If yes, give name and address of physician and arrange for a copy of the report to be submitted.

11. Name and address (Please type - include ZIP Code) 12. Signature 13. Date signed (Mo., day, year)

**INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION
BY WIDOW, WIDOWER, AND/OR CHILDREN**

- | | |
|-----------------------------|---|
| Who Should File Claim | <ul style="list-style-type: none">● This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim. |
| When Should Claim Be Filed | <ul style="list-style-type: none">● Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury. |
| What Documents Are Required | <ul style="list-style-type: none">● The marriage certificate(s) for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also, if appropriate, Letter of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed. |
| How to Complete Claim | <ul style="list-style-type: none">● All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent, 8-13 the surviving widow or widower, 14-14a, surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OWCP. |
| Funeral/Burial Allowance | <ul style="list-style-type: none">● Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document. |

See the reverse of this page for a definition of dependents and a description of benefits.

**DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN
UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)**

Widow or Widower	<ul style="list-style-type: none">● To qualify for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or later, no lump sum is paid. Instead, payments continue for life.
Children	<ul style="list-style-type: none">● Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	<ul style="list-style-type: none">● For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children. Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 40% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule. Federal payments are made through Direct Deposit. Therefore, a completed Form SF-1199A, Direct Deposit Sign-up must be submitted with Form CA-5. If the employee was covered under the Federal Employees' Retirement System (FERS), 5 USC 8116(d)(2) requires that Social Security benefits payable to beneficiaries, which are attributable to the deceased employee's Federal Service, are deducted from the beneficiary's compensation entitlement.
Funeral/Burial Allowance	<ul style="list-style-type: none">● Funeral and burial expenses up to a maximum of \$800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of \$200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	<ul style="list-style-type: none">● If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Privacy Act Notice

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Worker' Compensation programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 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 suggestion& for reducing this burden, to the Office of Workers' Compensation Programs, US Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., 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.

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington D.C. 20402

Exhibit 5

**Official Superior's Report of
Employee's Death**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



1. Name of Deceased Employee (Last, first, middle)		2. Date of Birth (Mo., day, year)		3. <input type="checkbox"/> Male <input type="checkbox"/> Female		4. Social Security No.	
5. Department or Agency				6. OWCP Agency Code		7. OSHA Site Code	
8. Name and Address of Reporting Office				9. Name and Office Phone Number of Employee's Official Superior			
10. Date and Hour of Injury (Mo., day, year) <input type="checkbox"/> AM c <input type="checkbox"/> PM		11. Date and Hour of Death (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM		12. Date and Hour Employee's Pay Stopped (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM			
13. Describe how injury occurred				14. Was employee in performance of duty when injury occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No (if No, explain) :			
15. Location where injury occurred		16. Location where death occurred		17. Immediate cause of death (Attach medical and autopsy report if available)			
18. Employee's pay rate as of		a. Base pay	b. Subsistence	c. Quarters	d. Other		
A. Date of injury		\$ per	\$ per	\$ per	\$ per		
B. Date pay stopped		\$ per	\$ per	\$ per	\$ per		
19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? yes <input type="checkbox"/> No				20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? Yes No			
21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) From To				22. a. Occupation code			
				b. Type code		c. Source code	
23. Did employee receive continuation of pay (COP) during period prior to death?				OWCP use - NOI code			
a. Pay rate used for COP		b. Inclusive dates of cop		24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:			
\$ per		From To					
25. Show date through which HBS deductions were last made (Mo., day, year)		26. Identify employee's Federal Retirement Plan: <input type="checkbox"/> CSBS <input type="checkbox"/> FERS <input type="checkbox"/> Other _____		27. If employee received medical care prior to death, give name and address of attending physician			
28. If injury was caused by a third party, give name and address of third party		29. Give name and address of the attorney representing the survivors if legal action is instituted against the third party		30. Show amount of third party recovery, if any \$			
31. If employee was a member of the Armed Services the United States show: Branch of Service: Serial No. (If known)				32. Has claim for survivor's benefits been filed with the Office of Personnel Management? <input type="checkbox"/> Yes <input type="checkbox"/> No			
33. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)							
34. Signature of Official Superior				35. Title		36. Date (Mo., day, year)	

Instructions for Completing Form CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate, when submitted to OWCP.

Form CA-5 or CA-5b should be supplied to the employee's spouse or next of kin.

If additional space is required, attach separate sheets and number the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter 810, Injury Compensation, Federal Personnel Manual.

Box 22a (Occupation Code), Box 22b (Type Code), Box 22c (Source Code), OSHA She Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Exhibit 6

Claim for Compensation

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



SECTION 1 EMPLOYEE PORTION

a. Name of Employee	Last	First	Middle	OMB No. 1215-0103 Expires: 08/31/2005
b. Mailing Address (Including City State, ZIP Code)				c. OWCP File Number
E-Mail Address (Optional)			d. Date of Injury Month Day Year	e. Social Security Number

SECTION 2 Compensation is claimed for:

	Inclusive Date Range		Intermittent?	
	From	To		
a. <input type="checkbox"/> Leave without pay	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Go to Section 3
b. <input type="checkbox"/> Leave buy back	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Go to Section 3, and Complete Form CA-7b
c. <input type="checkbox"/> Other wage loss; specify type, such as downgrade, loss of night differential, etc.	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Go to Section 3
d. <input type="checkbox"/> Schedule Award (Go to Section 4)	Type: _____		If intermittent, complete Form CA-7a, Time Analysis Sheet	

f. Telephone No./FAX No.
 () -
 () -

SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.)

Yes Name and Address of Business:

Name	Address	City	State	ZIP Code
Dates Worked: _____ Type of Work: _____				

No Go to Section 4

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

Yes Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"

No Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?

Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s) No - Complete Section 7

SECTION 5 List your dependents (including spouse):

Name	Social Security #	Date of Birth	Relationship	Living with you?	
				Yes	No
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>

a. Are you making support payments for a dependent shown above? Yes No If Yes, support payments are made to:

Name	Address	City	State	ZIP Code
b. Were support payments ordered by a court? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach copy of court order.				

SECTION 6 a. Was/Will there be a claim made against a 3rd party? Yes No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

<input type="checkbox"/> Yes	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment
<input type="checkbox"/> No			

c. Have you applied for or received payment under any Federal Retirement or Disability law?

<input type="checkbox"/> Yes	Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
<input type="checkbox"/> No				

SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature _____ Date (Mo., day, year) _____

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8	Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury:	Base Pay	Type _____	Type _____	Type _____
Date: ____/____/____	\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____
Grade: _____ Step: _____				
Date Employee Stopped Work:		Type _____	Type _____	Type _____
Date: ____/____/____	\$_____ per _____	\$_____ per _____	\$_____ per _____	\$_____ per _____
Grade: _____ Step: _____				

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence

a. Does employee work a fixed 40-hour per week schedule?

SECTION 9

(SUB), Quarter (QTR), etc. (List each separately) Yes No

1. If Yes, circle scheduled days: S M T W TH F S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY							
	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	6		
WEEK 2 From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
WEEK 1 From _____ to _____							
WEEK 2 From _____ to _____							

b. Did employee work in position for 11 months prior to injury? Yes No

If No, would position have afforded employment for 11 months but for the injury? Yes No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? No Yes Code

b. Basic Life Insurance? No Yes

c. Optional Use Insurance? No Yes Class _____

d. A Retirement System? No Yes Plan _____ (Specify CSRS, FERS, Other)

SECTION 11 Continuation of Pay (COP) Received (Show inclusive dates):

From ____/____/____ To ____/____/____

Intermittent? Yes — Complete Time Analysis Sheet, Form CA-7a
 No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

Sick Leave From ____/____/____ To ____/____/____	Intermittent? <input type="checkbox"/> Yes <input type="checkbox"/> No	If intermittent, complete Form CA-7a, Time Analysis Sheet. If leave buy back, also submit completed Form CA-7b.
Annual Leave From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Leave without Pay From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work From ____/____/____ To ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 13 Did employee return to work? Yes No

If Yes, date ____/____/____

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

Yes No If No, explain: _____

SECTION 14 Remarks:

SECTION 15 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature _____ Title _____ Date ____/____/____

Name of Agency _____ (Agency Official)

If OWCP needs specific pay information, the person who should be contacted is:

Name _____ Title _____

Telephone No. (____) _____ - _____ Fax No. (____) _____ E-Mail Address _____

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R. 10.106.

EMPLOYEE (or person acting on the employee's behalf) – Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) – Complete sections 8 through 15 as directed and promptly forward the form OWCP.

EXPLANATIONS – Some of the items on the form which may require further clarification are explained below:

<u>Section Number</u>	<u>Explanation</u>
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Exhibit 7

Instructions for Completing Form CA-7A Time Analysis

General: This form is used when claiming FECA compensation, including repurchase of paid leave. It must be used when claiming compensation for more than one consecutive period of leave.

Instructions for Employee:

Blocks 1, 2, and 3: Self-explanatory.

Block 4: Indicate beginning and ending dates covered by this form. These must be the same as on Forms CA-7 and CA-7b.

Block 5: If claiming compensation for any dates detailed in block 4, state total number of hours claimed for leave without pay and total number of hours of leave. This should be at least 10 hours unless this is your final claim.

Block 6:

1st Column: Show full date.

2nd Column: For each date noted in column 1, state "Y" if you are claiming compensation for that date and "N" if you are not.

3rd, 4th, 5th and 6th Columns: Show the number of hours of LWOP, number of hours worked, paid holiday hours, and number of hours of paid leave.

7th Column: Using the legend provided, indicate the type of leave used.

8th Column: State the reason you were off work. For each date for which compensation is claimed, there must be medical evidence supporting entitlement.

Sign and Date Form and Submit to the Appropriate Agency Official.

Instructions for Employing Agency:

Block 7: Verify accuracy of hours and status for each date listed. If challenging entitlement for any date, attempt to resolve discrepancies prior to submitting claim to OWCP. If discrepancy cannot be resolved, indicate the specific basis for the challenge in the space provided.

Exhibit 8

Leave Buy Back (LBB) Worksheet/
Certification and Election

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee Statement - Please carefully read instructions on pages 3 and 4 before filling out this form.

A. Name of Employee: <i>(Last, First, Middle)</i>	B. OWCP File Number:
C. Social Security Number:	
D. Period for Which Compensation is Claimed to Repurchase Leave	
From: ____ / ____ ____	To: ____ ____ ____

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate *(excluding overtime)*

- Date of Injury ____ / ____ / \$ _____
- Date Stopped Work ____ ____ ____ \$ _____
- Date of Recurrence ____ / ____ / ____ \$ _____

Enter the greatest amount and the effective date of that amount on line 1

____ / ____ ____
(effective date)

B. Additions to Base Pay:

If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 - by 52.

- Night Differential _____
- Sunday Premium _____ 3.
- Subsistence/Quarters _____ 4.
- Other *(Specify)* _____ 5.

C. Total Weekly Payrate *(Add lines 1 through 5)* _____ 6.

D. Compensation Rate *(Circle either 2/3 or 3/4)* _____ 7. 2/3 3/4

E. Total Hours Claimed on CA-7a _____ 8.

F. Total Hours Worked per Week _____ 9.

G. Formula *(for FECA Entitlement)*

$$\begin{array}{ccccccc}
 \text{_____} & \times & \text{_____} & \text{_____} & \div & \text{_____} & = & 10. \$ \text{_____} \\
 \text{(Weekly Payrate)} & & \text{(Compensation Rate)} & \text{(Hours)} & & \text{(Hours Wkd/Wk)} & & \\
 \text{See Line 6)} & & \text{See Line 7)} & \text{See Line 8)} & & \text{See Line 9)} & &
 \end{array}$$

II. Agency Certification:

H. Total Amount Due Agency to Repurchase Leave 11. \$ _____

Estimate of FECA Entitlement (See Line 10) 12. \$ _____

J. Balance Due Agency from Employee (Line H minus Line 1) 13. \$ _____

hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

(Signature of Agency Official)

(Title/Position)

Phone No _____

Date Signed: _____

Employing Agency Address for Check: _____

M. Employee Claim:

K. I hereby elect not to repurchase the leave used at this time.

L. I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my Job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above. OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

(Signature of Claimant)

(Date Signed)

Instructions Form CA-7B Leave Buy Back Worksheet

This form is intended to accompany Form CA-7, *Claim for Compensation*, when the employee is claiming leave buy back.

Things to Know About Leave Buy Back:

When an employee uses their sick or annual leave to cover an injury-related absence from work, they may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 3/4 with 1 or more dependents. The agency pays leave at 100% of salary. In order for leave to be reinstated, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency.

The employee's pay status must be changed to LWOP in order for compensation to be paid. Leave is not earned while in LWOP. Also, contributions to the Thrift Savings Plan (TSP) are not made during LWOP. Therefore, the repurchase of leave may result in a reduction in an employee's leave and/or TSP balance. Consult your personnel office to learn how the change to LWOP would effect you.

When a Leave Buy Back (LBB) payment is made during the same year that leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. Where leave repurchase is not completed during the same year in which leave is used, the employee may not adjust their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Further questions regarding tax implications of LBB should be addressed to the IRS.

A claimant may not repurchase leave used during a period they were eligible for COP.

When disability does not exceed 14 days beyond the COP period, 3 day LWOP must be charged before compensation can be paid. If leave was used for this period, compensation can not be paid for the 3 days, but the claimant will have to pay back leave paid during the 3 days to repurchase the leave.

Instructions to the Employee:

Please submit a claim for a minimum of 10 hours unless no further claim is anticipated. Medical documentation must be provided for all dates claimed.

1. Complete the Form CA-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete Form CA-7a following the instructions for completing that form.
2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.
3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, and the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.
 - a. If the total amount of FECA benefits estimated by the agency is not more than 10% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.
 - b. If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Office will offer you a new election with the correct amount of FECA benefits payable.

Instructions to the Agency:

Items A through D (top of form) are self-explanatory.

Section 1. Agency Estimate of FECA Entitlement:

Item A: Enter all three pay rate types and effective dates if applicable. Choose the greatest amount of the three and enter the amount and effective date in Line 1. A recurrent pay rate should only be used if:
(1) the employee stops work more than 6 months following their first return to regular, full time duty and
(2) the loss of time is due to disability rather than medical examinations or treatment.

For unusual situations, please refer to Payrate Desk Aid.

Item B- If the employee works a regular schedule, enter the differentials earned weekly. If an irregular schedule, give the total amount earned for the year prior to the date in Line 1 divided by the number of weeks worked in that year.

Please refer to Payrate Desk Aid for guidance on inclusions and exclusions. If in doubt, consult a Claims Examiner.

Item C- Add lines 1 through 5 and enter the total in Line 6.

Item D- Circle the appropriate rate: 2/3 for employees without dependents; 3/4 with dependents. Dependents include: spouse; children under 18 living with or supported by the employee; children under 23 in school full time; children over 18 incapable of self support; and parents wholly supported by the employee.

Item E- Enter the total hours *claimed*, from Form CA-7a

Item F: Enter the total hours in the employee's normal work week.

Item G: Formula for FECA Entitlement. Use this formula to calculate estimate of FECA entitlement and enter the result in Line 10.

Example of computation: The weekly pay from line 6 is \$574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:

$$\$574.00 \times 3/4 \times 82 \text{ hours} - 40 \text{ hours} = \$882.52$$

Section 11. Agency Certification:

Item H & I are self-explanatory. For Line J, subtract Line I from Line H.

Sign and date, and advise the employee of the amount they owe to the agency.

Section 111. Employee Claim:

If the employee elects not to repurchase the leave, retain the form in the agency files. If the employee elects to repurchase the leave, submit all claim documents (CA-7, CA-7a & CA-7b) plus any medical documentation to OWCP for processing.

Exhibit 9

**Authorization for Examination
And/Or Treatment**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 10-31-99

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

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)

3. Date of Injury (mo. day, yr.)

4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)

8. Signature of Authorizing Official:

9. Name and Title of Authorizing Official: (Type or print clearly)

10. Local Employing Agency Telephone Number:

11. Date (mo., day, year)

12. Send one copy of your report: (Fill in remainder of address)

13. Name and Address of Employee's Place of Employment:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

Department of Agency

Bureau or Office

Local Address (including ZIP Code)

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16
Rev. Jan. 1997

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (last, first, middle) _____

15. What History of Injury or Disease Did Employee Give You? _____

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No	16a. IDC-9 Code _____
--	--------------------------

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)	18. What is Your Diagnosis? 18a. IDC-9 Code _____
---	---

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt)
 Yes No

20. Did injury require hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)	21. Is Additional Hospitalization Required? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

22. Surgery (If any, describe type)	23. Date Surgery Performed (mo., day, year)
-------------------------------------	---

24. What (Other) Type of Treatment Did You Provide?	25. What Permanent Effects, if Any, Do You Anticipate?
---	--

26. Date of First Examination (mo., day, year)	27. Date(s) of Treatment (mo., day, year)	28. Date of Discharge from Treatment (mo., day, year)
--	---	---

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate) Total Disability: From _____ To _____ Partial Disability: From _____ To _____	30. Is Employee Able to Resume <input type="checkbox"/> Light Work Date: _____ <input type="checkbox"/> Regular Work Date: _____
--	--

31. If Employee is Able to Resume Work, Has He/She been Advised? Yes No If Yes, Furnish Date Advised _____

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? Yes No (If yes, state specialty) _____

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.	36. Address (No., Street, City, State, ZIP Code) _____ _____ 37. Tax Identification Number _____ 38. National Provider System Number _____ 39. Date of Report _____
--	---

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

Exhibit 10

Duty Status Report

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0103
 Expires: 08-31-05

OWCP File Number
 (If known)

SIDE A - Supervisor: Complete this side and refer to physician **SIDE B - Physician: Complete this side**

1. Employee's Name (Last, first, middle) 8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? Yes No. (If not, describe)

2. Date of Injury (Month, day, yr.) 3. Social Security No.

4. Occupation 9. Description of Clinical Findings

5. Describe How the Injury Occurred and State Parts of the Body Affected

6. The Employee Works 10. Diagnosis Due to Injury 11. Other Disabling Conditions

Hours Per Day Days Per Week

12. Employee Advised to Resume Work?
 Yes, Date Advised ____/____/____ No

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

13. Employee Able to Perform Regular Work Described on Side A?
 Yes, If so Full-Time or Part-Time _____ Hrs Per Day
 No, If not, complete below:

Activity	Continuous		Intermittent	Continuous		Intermittent
	#lbs.	#lbs.		#lbs.	#lbs.	
a. Lifting/Carrying: State Max Wt.			Hrs Per Day			Hrs Per Day
b. Sitting			Hrs Per Day			Hrs Per Day
c. Standing			Hrs Per Day			Hrs Per Day
d. Walking			Hrs Per Day			Hrs Per Day
e. Climbing			Hrs Per Day			Hrs Per Day
f. Kneeling			Hrs Per Day			Hrs Per Day
g. Bending/Stooping			Hrs Per Day			Hrs Per Day
h. Twisting			Hrs Per Day			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day			Hrs Per Day
j. Simple Grasping			Hrs Per Day			Hrs Per Day
k. Fine Manipulation (includes keyboarding)			Hrs Per Day			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day			Hrs Per Day
o. Temp. Extremes			range in degrees F			range in degrees F
p. High Humidity			Hrs Per Day			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day			Hrs Per Day
r. Fumes/Dust (Identify)			Hrs Per Day			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day			dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) Yes No (Describe)

15. Date of Examination 16. Date of Next Appointment

17. Specialty 18. Tax Identification Number

19. Physician's Signature 20. Date

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the OWCP, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

G. P. O. - 2000 - 188-099

Exhibit 11

Attending Physician's Report

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



Record of Examination

1. Patient's name	Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 08-31-05
-------------------	------	-------	--------	----------------------------------	---------------------	--

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) <input type="checkbox"/> Yes <input type="checkbox"/> No	ICD-9 Code _____
--	---------------------

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis?	ICD-9 Code _____
----------------------------	---------------------

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer)
 Yes No

9. Did injury require hospitalization? If no, go to item # 13 <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--------------------------------------	--------------------------------------	--

13. What treatment did you receive?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.
--	---	---

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.
---	---	--

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. If yes, on what date was he/she advised? mo. day yr.
---	---	---

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

25. Remarks

26. If you have referred the employee to another physician provide the following: Name Address City State ZIP	Specialty 27. What was the reason for this referral? <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment
--	---

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.
 Signature of Physician _____ Date _____

29. Name of Physician Address City State ZIP	30. Tax ID Number 31. Do you specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. If yes, indicate specialty
--	--

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE. THIS INFORMATION IS REQUIRED TO OBTAIN OR RETAIN A BENEFIT (5 USC 8101 et seq.).

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim filed under the FECA.

Exhibit 12

**Evidence Required in Support of a Claim
for Occupational Disease**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job actions.		5. Review and comment on employee's statement provided in response to Item no. 1.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.		6. If employee's job differs from official description, describe exactly his/her duties.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.		7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.		8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

Evidence Required in Support of a Claim for Work-Related Hearing Loss

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



IF YOU ARE FILING A CLAIM FOR HEARING LOSS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.		9. Review and comment on the employee's statement in response to questions 1-5.	
2. For each job title, describe source of noise, number of hours of exposure per day, and use of any safety devices to protect against noise exposure. State when safety devices were provided.		10. Describe all work-related exposure to hazardous noise, including: a. Locations of job sites. b. Nature of exposure to noise (machinery, etc.). c. Decibel and frequency level (noise survey report) for each job site. d. Period of exposure, hours per day, days per week. e. Type of ear protection provided.	
3. Give history of any previous ear or hearing problems.		11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Job sheet and employment record. c. All medical examinations pertaining to hearing or ear problems, including preemployment examination and all audiograms.	
4. Describe any hobbies which involve exposure to loud noise.		12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	
5. If you are no longer exposed to hazardous noise at work, give the date you were last exposed.			
6. If you have been examined or treated by a doctor for an ear or hearing problem, provide a medical report and audiograms.			
7. State whether a claim for workers' compensation benefits for this or any other condition affecting ears or hearing was ever filed. If so, give date of claim, name and address where filed, and benefits received.			
8. Give the date you first noticed your hearing loss.			
Give date you first related hearing loss to employment, and reason why.			

APPENDIX C Occupational Disease Checklists

Evidence Required In Support of a Claim
for Asbestosis-Related Illness

U.S. Department of Labor

Employee Standards Administration
Office of Workers' Compensation Programs



If you are filing a claim based on exposure to asbestos, use this checklist to identify the information needed from you and your employing agency. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service (see attached questionnaire).		9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days of week exposed and the types and frequency of safety precautions (mask, respirator, etc.) used (see attached questionnaire).		10. Provide exposure data, including air sample surveys or statements of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fiber/cc time weighted average. Also report concentrations of other pollutants and chemicals (see attached questionnaire).	
3. Describe any exposure you have had to other toxic substances. If none, state "None".		11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
4. Describe any breathing or lung problems you have had in the past and treatment received (see attached questionnaire).		12. Attach copies of the employee's: a. SF-171, Application for Employment b. Position description with physical requirements for last job held. c. Job sheet and employment record. d. Pertinent dispensary records. e. Most recent SF-50, Notification of Personnel Action. f. Laboratory test results and chest x-ray reports on file.	
5. Give your smoking history to include amount per day, and years (dates) you have smoked (see attached questionnaire).			
6. Submit a report from your physician, including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.			
7. Give the date you first consulted a physician regarding respiratory or asbestos-related disease.			
8. Submit reports of examination, treatment or hospitalization for any previous condition or pulmonary problem.		13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

Evidence Required in Support of a Claim
for Work-Related Coronary/Vascular Condition

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



IF YOU ARE FILING A CLAIM FOR CORONARY OR VASCULAR CONDITIONS (for example, heart attack, stroke, hypertension), THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.		6. Review and comment on the employee's statements in response to questions 1-5.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.		7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.		8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
4. Give your smoking history to include amounts and years (dates) you smoked.		9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
5. Provide a medical report from your physician which includes: a. Dates of examination and treatment. b. History given by you. c. Family history and other risk factors. d. Detailed description of findings. e. Copies of all diagnostic test results. f. Diagnosis. g. The clinical course of treatment followed. h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.		10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
		11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

**Evidence Required in Support of a Claim
for Work-Related Skin Disease**

U.S. Department of Labor
Employment Standards Administration
Office of Workers Compensation Programs



IF YOU ARE FILING A CLAIM FOR A SKIN CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Give a detailed description of employment factors you believe responsible for your condition, to include: <ul style="list-style-type: none"> a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure. 		6. Review and comment on the employee's statements provided in response to questions 1-5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.		7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
3. Describe any previous skin conditions from the time they began through the present.		8. Attach copies of the employee's: <ul style="list-style-type: none"> a. SF-171, Application for Employment b. Position description with physical requirements. c. Pertinent dispensary records. d. Copies of all physical examinations on file. e. Most recent SF-50, Notification of Personnel Action. 	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions.			
5. Attach or forward a medical report from your current physician to include: <ul style="list-style-type: none"> a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in Item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure. g. Work restrictions caused by the condition. 			

Evidence Required in Support of a Claim
for Work-Related Pulmonary Illness
(not asbestosis)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



IF YOU ARE FILING A CLAIM FOR PULMONARY CONDITION NOT RELATED TO EXPOSURE TO ASBESTOS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Describe the work conditions which caused or aggravated your pulmonary condition; include types of irritants, dates of exposure and hours per day. Describe any safety measures taken.		6. Review and comment on employee's statement provided in response to questions 1-5. Give periods, degree and nature of exposure. Explain safety precautions. Give full details of any tests which were made to determine the concentration of irritants. Have other employees been similarly affected?	
2. Explain the development of the present pulmonary condition and treatment from its beginning.		7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
3. Give your smoking history to include amounts and years (dates) you smoked.		8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination and any other pertinent medical records. d. Most recent SF-50, Notification of Personnel Action.	
4. Give the history of previous pulmonary conditions: include dates and nature of illness, and treatment records from all physicians and hospitals where you were treated.			
5. Attach or forward a medical report which includes the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may have and the factors of employment listed in Item no. 1.			

Evidence Required in Support of a Claim
for Work-Related Psychiatric Illness

U.S. Department of Labor
Employment Standards Administration
Office of Workers Compensation Programs



IF YOU ARE FILING A CLAIM FOR A PSYCHIATRIC CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.		7. Review and comment on the employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
2. Describe the progress and development of the work-related condition from its beginning.		8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
3. Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.		9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
4. Give a brief description of your personal activities, hobbies, and any other employment.		10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.		11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
6. Attach or forward a medical report as described on the reverse.		12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

**Evidence Required in Support of A Claim
for Work-Related Carpal Tunnel Syndrome**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



If you are claiming that your carpal tunnel or wrist problems are due to your job, use this checklist to identify the specific information needed from you and your employing agency to make a decision on the claim. All of the following information should be submitted with Form CA-2. Please return the checklist with statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Prepare a statement giving the following information:		1. Review the employee's statement, giving the following information:	
a. Provide an outline of your work history, including non-Federal employment and military service. For each job held, give your job title, agency/company name, and dates (period) of employment.		a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.	
b. For each job title, describe duties which required exertion with or repeated movement of the wrist or hand. Describe nature and frequency of motions required, and average number of hours a day/week you did such work.		b. Provide a day-to-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.	
c. Describe hobbies, physical fitness or other activities outside of work which also involved exertion or repeated motions of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.		c. Give date employee entered on duty in job requiring above duties. Also give the effective date(s) and description(s) of any changes in work assignments due to employee's condition and indicate whether duty changes resulted in changes in pay.	
d. If you have ever had an injury to the hand/arm/wrist, or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist, from/since birth, describe the injury or condition, and state when injury occurred or condition was found.		2. Send us copies of employee's:	
e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected, when you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.		a. SF-1 71, Application for Employment;	
2. Ask all doctors who treated you to send us a copy of reports or notes describing the condition, testing, and treatment given.		b. Position description with physical requirements for last job held;	
		c. All available medical records, including report of pre-employment examination;	
		d. SF-50s or equivalent documents for changes in assignment/pay due to condition.	
3. Ask the doctor currently treating your condition to provide a detailed current medical report to include the following specifics:			
a. Dates of examinations;		e. Treatment to date and prognosis;	
b. Complete medical history of condition;		f. Reasoned opinion explaining any causal relationship between the condition and your Federal civilian job.	
c. Medical diagnosis of condition;			
d. Findings and test results, specifically including: results of Phalen's and Tinel's Sign tests; physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence; results of nerve conduction velocity, and electromyographic testing;			
		It is MOST IMPORTANT that the doctor provide opinion as to the likely nature of the physical effects attributable to specified duties of your Federal job, and explain the medical reasoning which supports the opinion as to cause	

Exhibit 13

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																										
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSV or ID) (SSW) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																																																																																																																																																																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M SEX F																																																																																																																																																																																					
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>																																																																																																																																																																																					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																																																																																																					
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY M SEX F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M SEX F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE AN OTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.																																																																																																																																																																																					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																																																										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																																																																																																																																																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY																																																																																																																																																																																					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																																																																					
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																																																					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">24</th> <th colspan="2">A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th>From</th> <th>To</th> <th>Place of Service</th> <th>Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th colspan="2">DIAGNOSIS CODE</th> <th>\$</th> <th>CHARGES</th> <th>DAYS OR UNITS</th> <th>EPSTD Family Plan</th> <th>EMG</th> <th>COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>										24	A		B		C		D		E		F		G		H		I		J		K		From	To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$	CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE		1																							2																							3																							4																							5																							6																						
24	A		B		C		D		E		F		G		H		I		J		K																																																																																																																																																																					
	From	To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$	CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE																																																																																																																																																																											
1																																																																																																																																																																																										
2																																																																																																																																																																																										
3																																																																																																																																																																																										
4																																																																																																																																																																																										
5																																																																																																																																																																																										
6																																																																																																																																																																																										
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																																																																																																
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)					28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____																																																																																																																																																																																

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG, FECA AND EEOICPA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung, FECA and EEOICPA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional services by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations. For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, Black Lung and EEOICPA programs. Authority to collect information is in sections 205(a), 1862, 1872 and 1874 of the Social Security Act, as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq. and 10 USC 1079 and 1086; 5 USC 8101 et seq.; 30 USC 901 et seq.; 38 USC 613; E.O. 9397; and 42 USC 7384d, 20 CFR 30.11 and E.O. 13179. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor systems DOL/GOVT-1, DOL/ESA-5, DOL/ESA-6, DOL/ESA-29, DOL/ESA-30, DOL/ESA-43, DOL/ESA-44, DOL/ESA-49 and DOL/ESA-50 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Departments of Veterans Affairs, Health and Human Services and/or Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services received or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State law.

Instructions for Completing OWCP-1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEES' COMPENSATION ACT (FECA), the BLACK LUNG BENEFITS ACT (BLBA), and the ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT of 2000 (EEOICPA)

GENERAL INFORMATION—FECA AND EEOICPA CLAIMANTS: Claims filed under FECA (5 USC 8101 et seq.) are for employment-related illness or injury. Claims filed under EEOICPA (42 USC 7384 et seq.) are for occupational illnesses defined under that Act. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of the disability or occupational illness, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, or osteopathic practitioners within the scope of their practice as defined by State law. However, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

FEES: The Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services provided to claimants eligible under FECA and EEOICPA. OWCP uses a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA's Current Procedural Terminology (CPT); correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits, call the Dept. of Labor's Federal Employees' Compensation office or Energy Employees Occupational Illness Compensation office that services your area.

REPORTS: A medical report that indicates the dates of treatment, diagnosis(es), findings, and type of treatment offered is required for services provided by a physician (as defined above). For FECA claimants, the initial medical report should explain the relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

GENERAL INFORMATION—BLBA CLAIMANTS: The BLBA (30 USC 901 et seq.) provides medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the BLBA. For specific information about reimbursable services, call the Department of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

OWCP is authorized (5 USC 8101 et seq.; 30 USC 901 et seq.; 42 USC 7384d) to collect information needed to administer FECA, BLBA and EEOICPA. The information collected is used to identify the eligibility of the claimant for benefits, and to determine coverage of services provided. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. Failure to supply the claim number or CPT codes will delay payment or may result in rejection of the claim because of incomplete information.

SIGNATURE OF PHYSICIAN OR SUPPLIER: Your signature in Item 31 indicates your agreement to accept the charge determination of OWCP on covered services as payment in full, and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed). Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered or were rendered incident to your direct order. Finally, your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FORM SUBMISSION

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.

BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828, unless otherwise instructed.

EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, unless otherwise instructed.

INSTRUCTIONS FOR COMPLETING THE FORM: A brief description of each data element and its applicability to requirements under FECA, BLBA and EEOICPA are listed below. For further information contact OWCP.

- Item 1. Leave blank.
- Item 1a. Enter the patient's claim number.
- Item 2. Enter the patient's last name, first name, middle initial.
- Item 3. Enter the patient's date of birth (MM/DD/YY) and check appropriate box for patient's sex.
- Item 4. For FECA: leave blank. For BLBA and EEOICPA: complete only if patient is deceased and this medical cost was paid by a survivor or estate. Enter the name of the party to whom medical payment is due.
- Item 5. Enter the patient's address (street address, city, state, ZIP code; telephone number is optional).
- Item 6. Leave blank.
- Item 7. For FECA: leave blank. For BLBA and EEOICPA: complete if Item 4 was completed. Enter the address of the party to be paid.
- Item 8. Leave blank.
- Item 9. Leave blank.
- Item 10. Leave blank.
- Item 11. For FECA: enter patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For BLBA and EEOICPA: leave blank.
- Item 11a. Leave blank.
- Item 11b. Leave blank.
- Item 11c. Leave blank.
- Item 11d. Leave blank.
- Item 12. The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by witness and relationship to patient indicated.
- Item 13. Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, a person with a power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.
- Item 14. Leave blank.
- Item 15. Leave blank.
- Item 16. Leave blank.
- Item 17. Leave blank.
- Item 18. Leave blank.
- Item 19. Leave blank.
- Item 20. Leave blank.

- Item 21: Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.
- Item 22: Leave blank.
- Item 23: Leave blank.
- Item 24: Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.
 Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).
 Column C: not required.
 Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.
 Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.
 Column F: enter the total charge(s) for each listed service(s).
 Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.
 Column H: leave blank.
 Column I: leave blank.
 Column J: leave blank.
 Column K: leave blank.
- Item 25: Enter the Federal tax I.D.
- Item 26: Provider may enter a patient account number that will appear on the remittance voucher.
- Item 27: Leave blank.
- Item 28: Enter the total charge for the listed services in Column F.
- Item 29: If any payment has been made, enter that amount here.
- Item 30: Enter the balance now due.
- Item 31: Sign and date the form. Signature stamp or "signature on file" is acceptable.
- Item 32: Enter complete name of hospital, facility or physician's office where services were rendered.
- Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0055. We estimate that it will take an average of seven minutes to complete this collection of information, including time for reviewing instructions, abstracting information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and prior use of this common form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, Department of Labor, Room S3522, 200 Constitution Avenue NW, Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0055), Washington, DC 20503. **DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.**

Place of Service (POS) Codes for Item 24B

3	School	34	Hospice
4	Homeless Shelter	41	Ambulance – Land
5	Indian Health Service Free-Standing Facility	42	Ambulance – Air or Water
6	Indian Health Service Provider-Based Facility	50	Federally Qualified Health Center
7	Tribal 638 Free-Standing Facility	51	Inpatient Psychiatric Facility
8	Tribal 638 Provider-Based Facility	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center (CMHC)
12	Patient Home	54	Intermediate Care Facility/Mentally Retarded
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
20	Urgent Care	56	Psychiatric Residential Treatment Center
21	Inpatient Hospital	60	Mass Immunization Center
22	Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
23	Emergency Room – Hospital	62	Comprehensive Outpatient Rehabilitation Facility
24	Ambulatory Surgical Center	65	End Stage Renal Disease Treatment Facility
25	Birthing Center	71	State or Local Public Health Clinic
26	Military Treatment Facility	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other Place of Service
33	Custodial Care Facility		

Exhibit 14

Supervisor Responsibilities

- Refer to FAA Supervisors Guide to Workers' Compensation for more thorough description of responsibilities and procedures.
- Review employee allegations, witness statements, and other circumstances surrounding the alleged injury/illness and consider whether controversion/challenge is appropriate. If so, gather all relevant information and associate it with the claim form.
- Complete agency portion of CA-1/CA-2 claim form.
- In traumatic injury cases, authorize medical treatment with form CA-16 as discussed in the Supervisor's Guide. Advise employee of right to elect COP if employee is disabled and if one of the nine reasons for controverting COP is not relevant. If COP is being controverted, advise employee and HRMD Workers' Compensation Specialist (WCS) and prepare detailed statement for HRMD to transmit to DOL.
- Immediately bring claim form and all accompanying documentation to HRMD WCS. If further evidence is being gathered, **do not delay** bringing the claim form to the HRMD. Document that further information is forthcoming and meet with the WCS immediately.
- If employee is using COP, ensure medical documentation supporting disability due to the alleged injury is received within 10 workdays of the injury. If not, terminate COP and advise HRMD WCS. Ensure that all COP usage is properly tracked on employee's official timecard. Response to HRMD inquiry on 40th day of COP.
- If employee enters a LWOP status, advise employee s/he should complete form CA-7 for wage loss compensation. Upon receipt from employee, complete agency section of the form and immediately bring to HRMD WCS.
- While employee remains out of work, initiate contact on a weekly basis. This contact should be of a non-threatening, information gathering nature. Inquire as to employee's progress, medical status, and ability to return to both full and limited duty. Advise employee that you will provide whatever assistance you can to assist in his/her recovery. If no duty status is received, meet with HRMD WCS to issue CA-17 to physician. Advise employee that s/he remains an employee of the agency until advised otherwise and is thus expected to abide by all agency rules and regulations. Indicate that every effort will be made to accommodate the employee if limited duty is required while recovery continues.
- If medical evidence states that employee is capable of working with restrictions, make every effort to offer the employee a temporary position that meets his work tolerance limitations. If no light duty is available, meet with HRMD WCS to discuss vocation rehabilitation options at DOL.
- Cooperate with DOL claims examiners, nurse case managers and vocational rehabilitation specialists should they contact you. Advise HRMD WCS if contact is initiated by DOL or anyone acting on their behalf.
- Should you have any questions or concerns regarding your employee, arrange to meet with the servicing WCS.

Exhibit 15

HRMD Workers' Compensation Specialist Responsibilities

- Upon receipt of claim form(s), review for accuracy and completeness.
- Contact employee's supervisor to discuss specifics of case: possibility of controversion/challenge, employee duty status, receipt of medical evidence, supervisor responsibilities, etc.
- Complete case management worksheet, place on left inside of case folder. Initiate call-up date for next appropriate action.
- Enter claim form into WCIS. Enter call-up date in tickler function.
- Review case file at regularly scheduled intervals. Contact supervisor, employee, and DOL where appropriate to determine duty status, latest medical evidence, pending adjudicative and case management issues, etc. In conjunction with supervisor, send CA-17 to employee's physician if no current medical evidence is received stating anticipated return to work date and current work tolerance limitations.
- If COP is to be terminated, advise timekeeper to convert timecards.
- If employee enters LWOP status, review CA-7 for accuracy and completeness and immediately submit to DOL for processing. Request SF-52 from supervisor.
- Track case status, payment of medical bills and compensation payments, and other important case information in AQS and WCIS.
- If medical evidence shows employee is capable of working in limited duty capacity, contact supervisor to determine if light duty can be provided. If not, contact DOL and request vocational rehabilitation services. If medical evidence is missing or insufficient to establish ongoing disability from employment, contact DOL and request second opinion evaluation.
- Maintain contact with supervisor, employee, and DOL until such time as employee returns to duty, or DOL determines that employee is not expected to return.

Exhibit 16

Employee Responsibilities

- Report all injuries promptly to supervisor.
- File Form CA-1 if employee wishes to file a traumatic injury claim. *(if employee wants to claim Continuation of Pay (COP), employee must file Form CA-1 within 30 days of the date of injury and must provide supportive medical evidence to his or her supervisor within the first 10 days of receiving COP.)*
- File Form CA-2 if employee wishes to file an occupational disease claim.
- Provide evidence to support his or her claim.
- Inquire with attending physician about possibility of returning to work in a light duty capacity.
- Keep supervisor informed about medical status with regular reports from attending physician.
- Return to work within medical restrictions when possible.

Exhibit 17

Definitions

OWCP: Office of Workers' Compensation Programs of the Department of Labor. **FECA:** Federal Employees Compensation Act.

Continuation of Pay (COP): Continuance of traumatically injured employee's regular pay for up to 45 calendar days if supported by medical evidence establishing disability from employment.

Controversion: Withholding COP for one of nine specified reasons.

Employees' Compensation Appeals Board (ECAB): Appellate body which is a separate entity from OWCP, and which establishes precedents in administering the FECA. This is the highest level of appeal an employee may file for.

Five Basics: The basic requirements any employee must meet in order to establish a legitimate OWCP claim. Always considered in the same order, they are as follows: timely filed, civil employee, fact of injury, performance of duty, casual relationship.

Statutory Exclusions: Benefits are not payable if an injury is sustained as a result of any of the following: willful misconduct, intoxication, intent to injure self or others

Wage Loss Compensation: Benefits paid by the Department of Labor to disabled employees who are in a leave without pay status. Benefits are paid at 75% or 66 2/3% of the employee's salary and are tax-free. While these payments are issued by DOL, they are charged back to the agency.

Leave Buy Back: Compensation entitlement for leave repurchase when an employee used his/her own leave while out of work due to an employment injury.

Schedule Award: Compensation paid for permanent loss of use or permanent impairment to certain scheduled body parts and organs. This is paid on a proportional basis related to the percentage of impairment and the employee's pay rate.

Loss of Wage Earning Capacity: Compensation paid to an employee who has returned to work at a position paying less than he/she earned at his pre-injury state.

Attendants Allowance: Expenses paid to a licensed practical nurse, home health aide, or other similarly trained professional to care for an individual unable to attend to his basic physical need such as feeding, bathing and dressing.

Traumatic Injury: An injury caused by a definable external event occurring during one work shift.

Occupational Disease: An injury or illness caused by repeated exposure to some factor of employment occurring over a period longer than one work shift.

Recurrence: Spontaneous return of symptoms and/or disability due to the original injury, with no intervening injury or incident.

Exhibit 18

References

- Your HR Workers' Compensation Specialist
- FAA HR Web page - <http://www.faa.gov/ahr/Super/owc/index.cfm>
- DOL Web page - <http://www.dol.gov/esa/regs/compliance/owcp/fecacont.htm> (All information below is listed on this web page)
- DOL Publication CA-810 - Injury Compensation for Federal Employees - A Handbook for Employing Agency Personnel
- DOL Publication CA-550 - Federal Injury Compensation - Questions & Answers About the Federal Employees Compensation Act
- Title 20 Code of Federal Regulations, Part 10 -Office of Workers' Compensation Programs, Department of Labor
- Title 5 United States Code, Chapter 81 - Federal Employees' Compensation Act
- Federal Procedure Manual Part 2: Claims
- Decisions of the Employees' Compensation Appeals Board

Exhibit 19

Filing a Traumatic Injury Claim

- ✓ CA-1: Notice of Traumatic Injury
- ✓ CA-16: Authorization for Examination
- ✓ All forms for bargaining unit employees must be filed in accordance with bargaining agreement

14

OWCP Training for Supervisors

Prepared by FAA Office of Labor and
Employee Relations
Employee Relations and Benefits
Team AHL-100

15

CA-16

- ✓ Authorization for Examination/Treatment
- ✓ Guarantees payment of all non-invasive procedures and routine treatment/examination for 60 days after traumatic injury
- ✓ Supervisor completes front of form, physician completes back

16

FECA

- ✓ Federal Employees' Compensation Act (FECA) passed in 1916
- ✓ Exclusive Remedy
- ✓ Non-adversarial
- ✓ Administered by Department of Labor (DOL), Office of Workers Compensation Programs (OWCP)

Occupational Disease

- ✓ Condition produced over a period longer than one work day or shift (e.g. repetitive motion disorders, asbestosis)
- ✓ No eligibility for COP



17

Conditions of Coverage

- ✓ Timely Filing of Claim
- ✓ Federal Civilian Employee
- ✓ Fact of Injury
- ✓ Performance of Duty
- ✓ Causal Relationship



Filing an Occupational Disease Claim

- ✓ CA-2: Notice of Occupational Disease
- ✓ CA-35 a-h: Occupational Disease Checklist
- ✓ All forms for bargaining unit employees must be filed in accordance with bargaining agreement

17

CA-2

- ✓ Notice of Occupational Disease/Illness
- ✓ Two Parts
 - employee completes front
 - supervisor/HRMD completes back
- ✓ Must be transmitted to OWCP within 10 workdays

18

CA-35 (a-h)

- ✓ Occupational Disease Checklist
- ✓ Lists information required from both employee and supervisor
- ✓ Forms exist for seven different conditions and general occupational disease claims

19

Reporting Injuries to Safety

- ✓ Notify Safety Personnel That a Mishap Occurred:
 - The ROSHM (Regional Occupational Safety and Health Manager), or,
 - The LOB OSH POC (Line of Business Point of Contact for Safety), or
 - Other local safety representative, if any.

21

Reporting Injuries to Safety continued

- ✓ Investigate the incident: (who, what, where, when, why, how)
- ✓ Complete Form 3900-6
- ✓ Enter information into SMIS (Safety Management Information System) at <http://smis.jecbt.gov>
- ✓ Make entry on establishment OSHA log

23

COP and Controversion



24

COP - Basic Requirements

- ✓ Traumatic Injury
- ✓ Injury reported on CA-1 within 30 days
- ✓ Prima facie medical evidence within 10 calendar days from the date of filing
- ✓ Disability begins within 45 days

25

Controverting COP vs. Challenging Validity of Claim

- ✓ Controverting: withhold COP
 - must be for one of nine reasons cited on CA-1
 - indicate controversion on CA-1 and attach narrative statement and specific evidence substantiating controversion
 - advise employee
 - can also terminate COP if no prima facie medical evidence within 10 days

26

Controverting COP vs. Challenging Claim, continued.

- ✓ Challenging validity: claim doesn't meet one of five conditions of coverage
 - attach detailed statement describing circumstances behind challenge
 - include specific evidence: witness statements, accident investigations, timecards, etc.
 - pay COP pending OWCP decision

27

Filing a Claim for Compensation

- ✓ CA-7: Claim for Compensation
- ✓ CA-20: Attending Physician's Report
- ✓ CA-17: Duty Status Report



28

CA-7

- ✓ Claim for Compensation
 - used for filing for wage loss compensation, leave buy back, schedule award
- ✓ Two Parts
 - employee completes front
 - supervisor/HRMD completes back
- ✓ Must be transmitted to OWCP within five workdays of date of receipt from employee

29

CA-7 continued

- ✓ When to File
 - wage loss compensation: expiration of COP/commencement of LWOP and subsequent biweekly intervals of LWOP
 - leave buy back: within one year of date leave used or claim accepted, whichever is later
 - include CA-7a and CA-7b in package to OWCP
 - schedule award: maximum medical improvement

30