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1. INITIATING CLAIMS WITH OWCP

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Procedures initiating claims with OWCP for an employee who has (A) suffered a **Traumatic Injury**, (B) suffers from an **Occupational Injury or Disease**, (C) **Recurrence of Injury or Disease**, and (D) **Death**:

A. Traumatic Injuries

A **Traumatic Injury** is defined as a wound or other condition of the body caused by external force, including stress or strain within a single day or work shift. The injury must be identifiable by time and place of occurrence and member of the body affected.

For T**raumatic Injuries**, the employee (or someone acting on his/her behalf) must report the injury by completing a Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," to his/her manager/supervisor. There is a portion of the Form CA-1 that will need to be completed by the manager/supervisor. The manager/supervisor should submit the completed Form CA-1 through appropriate agency channels to insure claim is received by the OWCP District Office as soon as possible, but no later than 10 working days after receipt of Form CA-1 from the employee. The employee must report the injury by completing the Form CA-1 within 30 days of the injury in order to be eligible for Continuation of Pay (COP) entitlements and within three (3) years to meet the FECA time limits of a claim. If the claim is not filed within the 30-day period, and COP is not authorized, employee may file a Form CA-7, "Claim for Compensation", for loss of wage earnings. However, medical documentation is required within 10 days of the injury or the entitlement to COP will be suspended.

When warranted, the manager/supervisor will provide the injured employee a Form CA-16, "Authorization for Examination and/or Treatment." Form CA-16 may be obtained through your manager /supervisor. The CA-16 is used to provide authorization for treatment. The manager/supervisor should complete the front of the Form CA-16 within 4 hours of the request whenever possible. If there is concern that the facts of the injury are in dispute, the supervisor can check the appropriate box on the Form CA-16 (6.B.2) but still provide the employee with the form. In the event there is no time to complete the Form CA-16, the manager/supervisor may authorize medical treatment by telephone and then forward Form CA-16 to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is not allowed under any other circumstances. However, Form CA-16 may not be used to authorize treatment for Occupational Disease or Illness, without prior approval from OWCP.

The employee has the right to choose his/her initial treating physician. A physician is defined as a surgeon, podiatrist, dentist, clinical psychologist, optometrist, osteopathic, practitioner, and chiropractor within the scope as defined by state law. However, the services of chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. A chiropractor may also provide services in the nature of physical therapy under the direction of a physician. The term "physician" doesn't include physician assistants or nurse practitioners.

B. Occupational Disease or Illness

An **Occupational Disease or Illness** is defined as a condition produced in the work environment over a period longer than one (1) workday or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons or fumes, or other continuing conditions of the work environment**.** For an **Occupational Disease or Illness**, the employee (or someone acting on his/her behalf) must report the disease of illness by completing a Form CA-2, "Notice of Occupational Disease and Claim for Compensation." to his/her manager/supervisor.

In addition to the completed Form CA-2, the employee must provide the completed applicable Form CA-35 a-h, "Evidence Required in Support of a Claim for Occupational Disease," for the disease or illness claimed. The information requested should be submitted with the Form CA-2. If all of the information cannot be completed at the time of submitting the Form CA-2, additional information should be forwarded in a timely manner to OWCP through the employer, once an OWCP Claim Number is received.

COP is not authorized and Form CA-16 may not be used to authorize treatment for Occupational Disease or Illness, without prior approval from OWCP. (Form CA 20, Attending Physician's Report, can be used.)

The manager/supervisor should submit the completed Form CA-2 through appropriate agency channels to insure claim is received by the OWCP District Office as soon as possible but no later than 10 working days after receipt of Form CA-2 from the employee.

C. Recurrence of an Injury or Occupational Disease or Illness

A **Recurrence** of disability is defined as a spontaneous return or increase of disability due to a previous injury or occupational disease without intervening cause, or a return or increase due to a consequential injury. (A consequential injury is a new injury, which occurs, as a result of a work related injury). A recurrence of a disability differs from a new injury in that

with a recurrence, no event other than the previous accounts for the disability.

When an employee, after returning to work, is again disabled due to a prior injury or occupational disease, the employee completes and submits Form CA-2a, “Notice of Employee’s Recurrence of Disability and Claim for Pay/Compensation,” to their manager/supervisor. If the recurrent disability is related to the original injury, the employee is entitled to medical treatment and compensation.

The employee has the burden of establishing that the current condition is related to previous accepted injury or occupational disease condition, with or without work stoppage. If the employee was entitled to use COP and the 45-days of COP have not been exhausted, he/she may elect to use the remaining days, if the 45-days have not elapsed, since first return to duty; otherwise, the employee may elect to use sick, annual leave or leave without pay.

D. Death Benefits

Death Claim is defined as when an employee dies because of an injury incurred in the performance of duty. For **Death Claims,** the manager/supervisor uses Form CA-6, “Official Supervisor’s Report of Employee’s Death”, to report the work related death of an employee.

Claim for Death Benefits. The survivors of a deceased employee should use Form CA-5, “Claim for Compensation by Widow/Widower, and/or Children” or Form CA-5b, “Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren” to submit claims for death benefits. The survivors should complete the front of the appropriate form, while the attending physician should complete the medical report on the reverse. This should include a copy of the death certificate, marriage certificate, if the spouse is making the claim, a copy of any divorce or annulment decree if the decedent or spouse were formally married and/or copies of birth certificates of any children for whom claim is being made.

E. Exposure to Infectious Agents

FECA doesn’t provide for payment of expenses associated with simple exposure to an infectious disease without the occurrence of a work related injury. Infectious disease includes tuberculosis, hepatitis, and HIV (Human Immunodeficiency Virus). Fear of exposure to an infectious agent doesn’t entitle the worker to benefits under the FECA, since no definable injury has occurred.

Federal Law 18 U.S.C.1922 provides that a manager/supervisor cannot refuse to accept a Notice of Injury, Illness or Death.

If the validity of the claim is in challenged, all allegations must be reported to OWCP by factual evidence.

2. CONDITIONS OF COVERAGE

2. CONDITIONS OF COVERAGE

Claims for Compensation must meet certain requirements before being accepted. These five (5) requirements must be met within the sequence below and if not, claim will be given due process:

A. Time

Claim for compensation must be filed within 3 years of the injury or death. However, if a claim is not filed within 3 years, compensation may still be paid if written notice of the injury was given within 30 days, or the employer had actual knowledge of the injury within 30 days after it occurred.

For a disease or illness, the employee should file for compensation within 30 days of when the employee realized the disease or illness was caused or aggravated by the employment; reasonably should have been aware of a relationship between medical condition and the employment; or date of employee's last exposure.

B. 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.

Temporary employees are covered on the same basis as permanent employees. Also, part-time, seasonal, and intermittent employees are covered.

C. Fact of Injury or Occupational Disease or Illness

Once the requirements of time and civil employee have been met, the employee must establish the burden of proof if an injury or disease was sustained. Injuries sustained in the performance of duty are separated into two categories:

Two factors are involved in the determination of whether the employee did in fact suffer the injury:

1) Occurrence of the Event: Did the incident occur at the time, place and in the manner claimed? Determination is based on factual evidence, including statements from employees, manager/supervisor, and any witnesses. An injury need not be witnessed in order to be compensable. A manager/supervisor who believes, however, that the employee's testimony is contrary to the facts, manager/supervisor

should supply pertinent information to support his/her beliefs. To controvert Continuation of Pay (COP) and/or to Challenge the claim, this process should be done at time of submission and employee should be advised.

2) Existence of a Medical Condition: Determination must be made to decide whether accident or employment factor resulted in an injury or disease? The attending physician's statement will determine that a medical condition is present that could be related to the accident or employment factor, though the medical report need not relate the condition to the incident. The FECA does not provide for payment of expenses associated with simple exposure to an infectious disease without the occurrence of a work-related injury. Both a work-related injury and exposure to a known carrier must occur before OWCP can pay for diagnostic testing. (Fear of exposure to an infectious agent does not entitle the worker to benefits under the FECA, since no definable injury has occurred.)

D. Performance of Duty

If the first three requirements have been accepted, performance of duty (POD) when the injury occurred must be established. An injury is generally said to have occurred in the performance of duty if the injury arose as specified below.

1) **Agency Premises** includes areas immediately outside the building, such as steps and sidewalks if they are federally owned or maintained.

   a. **Outside Working Hours -** Coverage is extended to employees who are on the premises for a reasonable time before or after working hours. (Not extended if visiting the premises for non-work related reasons.)

   b. **Representation Functions -** Injuries to employees performing representation functions entitling them to official time are covered.

   c. **Parking Facilities -** owned, controlled or managed are considered agency premises

2) **Off-Premises Injuries** coverage is extended to workers who are sent on errands or special missions and workers who perform services at home.

   a. **To and From Work -** Employees are not eligible for coverage when injured en route between work and home, **except** when the agency furnishes transportation to and from work, when employee is

required to travel during a curfew or emergency, or the employee is required to use their personal vehicle during the workday.

b. Lunch Hour - Lunch hour injuries off the premises are not covered **unless** the employee is in travel status or is performing regular duties off premise.

c. Travel Status - Employees in a travel status may be covered for reasonable incidents of their temporary duty. When filing a claim for injuries that occur in a travel status, a copy of the travel authorization should be included.

d. Vehicular Accidents - A police report should be attached to any claim involving a traffic accident, along with a diagram or map showing the location of the accident.

3) Other Factors. Injuries that occur under other circumstances not governed by the premises rules must be determined on a case by case basis. They may include, but not limited to:

a. Recreation - Formal recreation, for which an employee is paid or required to perform as a part of training or assigned duties. Informal recreation, such as a physical fitness or physical training activity, agency sponsors or directs.

b. Horseplay - Horseplay is covered if the activity was one, which could be reasonably expected where a group of workers are closely associated for extended periods of time. Determination must be made on whether activity was a reasonable incident of the employment or if it was an isolated event.

c. Assault - Injury or death caused by another person may be covered if it is established that the assault was accidental and resulted out of an activity directly related to the work.

d. Emergencies - Employees who may step outside the realm of employment to assist in an emergency situation are covered.

E. Causal Relationship

Between the condition claimed and the injury or disease sustained is determined after the four (4) previous factors have been considered. This factor is based **entirely** on medical evidence provided by physicians who have examined and treated the employee.

1) **Kinds of Causal Relationship.** Relationship to the injury or disease may be determined in any one of four (4) ways:

   a. **Direct Causation -** Injury or factors of employment result in the condition claimed through a natural and unbroken sequence.

   b. **Aggravation -** Pre-existing condition is worsened, either temporarily or permanently, by a work-related injury.

   c. **Acceleration -** Work related injury or disease may hasten the development of an underlying condition.

   d. **Precipitation -** Latent condition, which would not have manifested itself on this occasion but for the employment.

2) **Medical Evidence.** Medical opinion is required, and must come from a physician who has examined or treated the employee for the condition claimed, for resolution. Medical must also be provided for pre-existing conditions involving the same part of the body, differentiating the effects of the employment-related injury or disease from the pre-exiting condition. OWCP district medical director/advisor may request additional medical opinion from a specialist in the medical field pertinent to the injury or disease.

3) **Consequential and Intervening Injuries.** An injury that occurs outside the performance of duty that affects the compensability of a work-related injury.

   a. A new injury, which occurs as a work-related injury, is considered a consequential injury.

   b. An injury, which occurs outside the performance of duty to the same part of the body originally injured, is considered an intervening injury.

F. Statutory Exclusions

Circumstances of a claim may raise the issues of willful misconduct, intention to bring about the injury or death of oneself or another, or intoxication. Benefits may not be payable if an injury is sustained as a result of:

- **Willful misconduct –** Deliberate.

- **Intoxication** (whether by alcohol or illegal drugs). The record must establish both the extent to which the employee was intoxicated at the

time of injury and the particular manner in which the intoxication **caused** the injury.

- **Intent to injure** self or others. If the factual and medical evidence show that the employee was not in full possession of their faculties, the injury may be compensable.

3. CONTINUATION OF PAY

3. CONTINUATION OF PAY (COP)

Continuation of Pay (COP) is continuation of regular pay up to 45 calendar days for periods of disability and or medical care, which occur in connection with a **Traumatic Injury.** COP must begin within 45 days of the injury.

A. Entitlement –

Permanent and Temporary employees are entitled to COP when T**raumatic Injury** is reported within 30 days. Medical documentation must support all periods of COP. Normally, COP will begin the day following the date of the traumatic injury. **Except** for Injuries that occurred prior to the start of the workday, then COP will begin on date of injury. Medical documentation must be received within 10 days of the injury to receive COP and COP will be terminated if medical documentation is not received within the allotted time frame. For any additional details, please contact your worker's compensation specialist.

1) Leave Usage:

a. The use of annual and sick leave will be counted against the 45 days of entitlement of COP. Therefore, COP is not extended beyond 45 days of the combined absences.

b. Decision to use leave over COP is not irrevocable. Employee who uses leave can later elect COP within one year of the leave usage or date the case is accepted by OWCP, whichever is later.

2) Annual or sick leave cannot be required when a **Traumatic Injury** is sustained. In the event claim is **not** approved, the supervisor will then retroactively change days of COP used to appropriate leave.

B. Controversion of COP –

The agency may refuse paying COP for any one of the nine (9) reasons, provided FECA. These nine (9) reasons are listed on the Instructions for completing Form CA-1. The agency may dispute an employees right to receive COP on other grounds, for instance, employee was not performing assigned duties when the injury occurred or condition claimed was not a result of work related injury. Evidence such as witness statements, pictures, accident reports, or time sheets would support objections to COP. Advise employee of controversion.

C. Unacceptable Reasons for Controverting COP

1) Injury was not witnessed

2) Employee was careless

3) Employee is a “bad” employee and doesn’t deserve any benefits

When controverting COP the validity of the claim is not being questioned, just the entitlement to COP. If the validity of the claim is challenged, all allegations must be reported to OWCP by factual evidence.

D. Calculating COP

1) The pay rate for COP purposes is equal to the employee’s regular weekly pay rate excluding overtime pay.

2) Changes in pay, which would have occurred during the 45-day period are to be reflected, i.e., promotions, changes to lower grade, and step increases.

3) The first day of COP is the day following the Date of Injury (DOI) when there is an immediate time loss.

4) If there is immediate time loss on the DOI and if the employee was injured during official work hours, time lost is then charged to Administrative Leave.

5) If employee is injured before work hours and there is immediate time loss, the first day of COP is the DOI.

6) If disability wasn’t immediate, the time line begins on the first return to work date – so long as it was within the 45 days of DOI.

7) If continual disability for work begins within 45 days after the first return to work, and all 45 days of COP haven’t been used, then COP continues until 45 days of COP have been used.

8) If the disability for work was intermittent, COP can be used only up to 45 calendar days after the first return to work – even if less than 45 days have been used.

9) COP looks at calendar days, not just workdays.

10) Using any part of a day towards COP makes it a COP day (1 hr COP = 1 day COP). (If the employee is absent for the remaining workday, time loss should be covered by leave, LWOP, or AWOL, since the absence is beyond the time needed to obtain medical treatment and cannot be charged to COP.)

11) Medical documentation for time lost must be certified by physician.

12) COP is charged for weekends and holidays if medical evidence shows injured worker (IW) was disabled on those days.

13) Determining factors for COP are disability for work or absence for obtaining medical care for injury.

E. Light Duty and COP

1) When medical condition shows employee is no longer totally disabled, employee is required to return to work (RTW) in any reasonable and suitable light or limited duty offer.

2) If offer is refused, COP should be terminated as of the date of refusal or after five (5) days from date of offer, whichever is earlier. OWCP will then make formal decision.

3) If the effects of the injury require that an employee lose elements of pay (e.g., the assignment of a night shift worker to a day shift in order to perform prescribed light duty), COP should be granted for the lost elements of pay (e.g., night differential).

4) Assignment of light or restricted duties, without a personnel action and without loss of pay, is not counted as continued pay under section 8118 and does not decrease the number of days available to the claimant. 20 C.F.R. 10.217.

F. Recurrences –

If an employee suffers a recurrence of the disability, they may use the remainder of the COP if no more than 45 days have elapsed since the date of the first return to work. If recurrence begins later than 45 days after the first return to work, the agency should not pay COP even though some entitlement may remain unused. A period which begins before the 45 day deadline and continues beyond it may be charged to COP as long as the period of time is **uninterrupted.**

G. Terminating COP –

Where the employer has paid COP, it may be stopped only when at least one of the following occurs:

1) Medical evidence is not received within 10 calendar days after the claim is submitted.

2) Medical evidence shows that the employee is not disabled from his/her regular position.

3) Medical evidence shows that the employee is capable of performing light duty, and the employee has refused a suitable written job offer.

4) Employee returns to work with no loss of pay.

5) Employee's period of employment expires.

6) OWCP directs the employer to stop COP.

7) COP has been paid for 45 days.

H. References

- Publication CA-810
- Publication CA-550
- 20 CFR 10.200-10.224
- FECA as amended, 5 U.S.C. 8101 et seq.
- FECA Procedure Manual, 2-0807
- Online Training and Presentations on the DFEC homepage: http://www.dol.gov/

4. CLAIMS PROCESSING

4. CLAIMS PROCESSING –

Certain procedures and responsibilities have to be accomplished once the forms and information have reached OWCP for appropriate adjudication of claim.

A. Initial Processing –

Once claim is received with all supporting documentation (when possible) claim number will be assigned to the case. OWCP will notify the employee and agency once claim has been received. Uncontroverted claims with medical bills totaling less than $1500 will be administratively closed by OWCP. Thos claims not meeting that criteria will be assigned to a claims examiner for formal adjudication. When additional information is required, the claims examiner will notify the employee by letter with a copy to all parties to the claim.

B. Requesting Information –

Request for information is request by written notification. The employee and the agency is entitled to receive under the Privacy Act, one copy of the case file from OWCP free of charge. Request for records is not necessary under the Freedom of Information Act.

C. Representation –

Representation is not required, but if employee desires to be represented they must designate in writing before OWCP will recognize them, and they can only have one representative at a time. Such representatives may include, attorney, union representatives, family member or friend. OWCP does not pay representative fees. However, OWCP must approve such payments before payment is made by employee .

D. Third Party. -

OWCP may seek damages if a party other than the injured employee or another employee of the agency appears to be responsible. OWCP may advise the employee to request damages from that individual, company, or product manufacturer. Supervisors are encouraged by OWCP to investigate the possible Third Party of any claim and provide all information obtained. An employee should not attempt to settle claim without first obtaining approval from OWCP. Medical and compensation benefits will be paid while claim is pending against possible Third Party. If any monies are awarded, OWCP will determine distribution.

E. Burden of Proof –

Responsibility for establishing Burden of Proof is the claimant's. OWCP will assist the claimant to meet this responsibility. By law, any information requested by OWCP is to be provided by the agency, but this does not relieve the claimant from their responsibility of burden of proof to provide medical or factual evidence to adjudicate their claim. When this process is not timely met, delays in OWCP adjudicating cases and paying claims will result. Information requested by OWCP should be received within 30 days from the date of the request. When additional evidence is requested by OWCP to the supervisor, a copy will be sent to the employee and vice versa. Once claim is accepted, the burden of proof shifts from the employee to OWCP.

5. CHALLENGING VALIDITY OF CLAIMS

5. CHALLENGING VALIDITY OF CLAIMS –

If the validity of a claim is questioned, the supervisor should investigate the circumstances and report the results to OWCP. However, filing of the claim should not be delayed.

A. Allegations

Must be supported by factual evidence.

1) **Different Versions** of incident by several witnesses, whose accounts differ, should provide supervisor with written statements of their information.

2) **Previous Injury –** Agency should request statements from witnesses if on the date on the claimed injury the appearance of a previous condition or injury.

3) **Time Frame –** Agency should provide written statement if the injury is reported after a lapsed time from the reported date of injury.

4) **Outside of Employment –** If employed outside of the agency and injury is claimed, supervisor should inquire about the duties of the other employment and report it to OWCP.

B. Notifications and Decisions –

OWCP will notify employee by letter when claim is accepted, additional information is requested, or denied.

1) **Hearing –** Employee is entitled to an oral hearing, requested in writing within 30 days of the decision and if reconsideration has not already been requested. The request for oral hearing should be sent to the Branch of Hearings and Review at the address stated in the decision letter and hearings will be held within 100 miles of the employee's home. Employee may provide oral testimony or written evidence in support of the case. If review of the record is chosen, employee may not present oral testimony but may submit additional written evidence. Agency will be notified of the date and time and may send representative to the hearing and request a copy of the transcript unless specifically invited by the employee or the OWCP representative. The agency may not participate in the proceedings. OWCP will allow the agency representative 20 days to submit additional comments or documents, which will then grant the employee an additional 20 days to review and comment. OWCP will then issue a

formal decision, which will include further appeal rights for the employee.

2) **Reconsideration –** Employee is entitled to a reconsideration of a formal decision requested in writing within one (1) year of the date that the formal decision was issued. This request should include the reason for the reconsideration and be supported by relevant evidence not previously submitted. If criteria is met, OWCP will provide the agency with a copy of the request and allow 20 days for additional comments and/or documents to be submitted. The employee will be allowed to review and comment for an additional 20 days from the date that the formal decision was issued. OWCP will then issue a formal decision, which will include further appeal rights for the employee.

3) **Employees' Compensation Appeals Board (ECAB) –** A request by the employee for the ECAB to review should be requested within 90 days of the date of decision if residing within the continual U.S. or Canada, and 180 days if residing elsewhere and filed directly with the ECAB at the address shown in the formal decision. ECAB may for good cause excuse failure for timely file if request is received within one (1)year of the date of decision. This is the highest authority in FECA claims. New evidence is not considered when ECAB is reviewing the case.

6. BENEFITS UNDER FECA

6. BENEFITS UNDER FECA

Medical services are authorized for treatment of any condition, which is casually related to factors of federal employment. There is no monetary limit imposed on the amount of medical expenses or for the length of time for which they are paid. Reasonable and customary fees must be shown for the services and treatment that are required. Medical bills may be reduced due to exceeding the amount allowed by the OWCP Fee Schedule. Examinations, treatment, and related services such as, medications, hospitalization, and transportation are included in medical care. Preventative care is **not** authorized.

A. Physician Definition–

A physician is defined as a surgeon, podiatrist, dentist, clinical psychologist, optometrist, osteopathic, practitioners, and chiropractor within the scope as defined by state law. The term “physician” doesn’t include physician assistants or nurse practitioners.

1) **Chiropractors** may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist, except that a chiropractor may also provide services in the nature of physical therapy under the direction of a physician. (A subluxation is defined as an incomplete dislocation, off centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically, which must be demonsratable on any X-ray film.) If Form CA-16, is issued to a chiropractor of emergency care and the condition is diagnosed other than a subluxation, then OWCP will honor the charges incurred and terminate the authority of the Form CA-16. Employee is then entitled to select another attending physician.

2) **Excluded Physicians** include those whose licenses to practice medicine have been suspended or revoked by a state licensing or regulatory authority or who have been excluded from payment under FECA.

B. Physician Choice –

The entitlement to choose a physician for initial treatment is made by the employee.

1) **Employee** may choose any licensed physician who is not excluded or if available, may choose to be treated at a Government medical facility. Employing agency may not interfere with the employee’s right to choose a physician or require an employee to go to a physician who is employed by the agency or under a contract. However, except for

referral by the attending physician, any change in treating physicians after the initial choice must be authorized by the OWCP; otherwise, OWCP will not be liable for the expenses of the treatment and the employee may be responsible for the cost of the unauthorized medical care.

2) **Physician Referrals –** Initial physician may refer employee to facilities, which provide laboratory services, X-rays, or the services of specialists.

3) **Change of Physician –** Authorization for any change of a treating physician, other than a referral must be authorized by OWCP or payment will not be made for treatment. This request should be made in writing to include the reason for request.

4) **Transfer of Medical Facility –** Agencies do not have the authority to transfer medical care. If medical care is not available locally or the transfer of medical care is recommended, the agency must contact OWCP.

C. Medical Treatment –

The following medical treatment and services should be approved by OWCP to guarantee payment in advance. Treating physician is responsible for requesting services:

1) Non emergency surgery may not be approved without Second opinion.

2) Medical supplies, to include hospital beds, wheel chairs, etc.

3) Private hospital rooms.

4) Orthopedic shoes and appliances.

5) Nursing homes.

6) Physical Therapy.

7) Lip reading and hearing aid services.

8) Hearing and Seeing Eye dogs.

9) Health Club Memberships.

D. Request from OWCP –

Sometimes medical issues which can't be resolved due to a different opinion from treating physician and the district medical director/OWCP Advisor, an opinion will then be requested from a physician who specializes in the field pertinent to the injury. OWCP will arrange and advise the employee of the examination. Employee will be compensated for the travel expenses and wage loss due to the examination. OWCP is responsible for the payment of the additional examination. If the employee fails to report for scheduled medical examination, benefits will be suspended by OWCP.

E. Request from Agency –

FECA does not address the issue of medical examinations requested by the employing agency. OPM Regulations 339 and 353 grant agency's authority to arrange for a medical examination of any employee who files a compensation claim by a physician of the agency's choice and expense. This examination is used for the sole purpose to determine if the employee can work in some sort of capacity. The medical examination cannot be used to intimidate the employee and the results of the exam may not affect the entitlement of compensation.

F. Bill Payment –

Payment and reimbursement for OWCP will be for only those services for work-related injuries. Medical documentation or clinical notes from the physician is required to support date of medical service.

All bills must include, at a minimum, employee's Name, Provider Name and Address, Diagnosis, Itemized List of Services with Charges, Tax Identification number, and Provider Identification Number. Bill must be itemized for the evaluation of the charges. Current Procedural Terminology (CPT) Code for each medical, surgical, X-Ray, or laboratory service should be shown on the bill along with the Date of Service for which the service or supply was provided.

Bills will not be paid, unless they are received by OWCP on/or before December 31st of the year following the calendar year, for which the expense was incurred or the claim was first accepted by OWCP, whichever was the later. Bills will be paid according to the amount allowed by the OWCP Fee Schedule. If the charges are reduced due to exceeding the amount allowed by the OWCP Fee Schedule, the employee is not liable for the difference.

1) Forms –

a. AMA Standard Billing Form OWCP-1500a/HCFA 1500.

- Physicians
- Dentists
- Nursing Services
- Laboratory, E-Ray Facilities
- Chiropractors
- Therapists
- Medical Suppliers

b. UB-82 or UB-92

- Hospital
- Nursing Homes

c. NCPDP Universal Billing Form or Equivalent

- Pharmacy
- Provider Letter head

d. Provider Letterhead

- Ambulance

e. CA-915 Claim for Medical Reimbursement (out of pocket expenses)

- Prescription Drugs
- Medical Appointments
- Medical Supplies

f. OWCP – 957 Medical Travel Refund Request (Medical Care Only)

- Private Auto – Standard Mileage Rate for Government travel
- Bus
- Subway
- Taxi
- Special Equipped Vehicle

g. Incorrect Payments - If an incorrect payment, either partially or totally is received, the check should be returned to OWCP immediately, (if you know that it is incorrect).

2) Medical Provider Payment Enrollment Process - Affiliated Computer Services (ACS).

a. Provider must enroll with Affiliated Computer Services (ACS) – Enrollment Unit, http://owcp.dol.acs-inc.com in order for bills to be paid.

b. Provider Checklist:

- Provider enrolled with ACS/ACS Provider Number on bill.
- FECA Case Number on medical bill and all documentation.
- Medical Documentation submitted to OWCP.
- Prior Authorization requested.
- Diagnosis Code from injured employee/OWCP letter.

3) Submission of Medical Bills/Documentation.

a. U.S. Dept of Labor
Central Mailroom
P.O. Box 8300
London, KY 40742-8300

b. Claim Number should be on all documentation submitted in the upper right hand corner.

G. Compensation –

There are various forms of compensation benefits available to injured employees and survivors in death claims. With a work-related disability you may be entitled, depending on the nature and extent of the disability incurred, to receive one or more types of wage-loss compensation. Compensation is based on loss of wages and payable after continuation of pay has expired, or when pay loss begins as the result of continuing injury-related disability. No compensation is payable during a three (3) day waiting period for a disability that lasts more than fourteen (14) days. If COP is used, the three (3) day waiting period will begin after the 45th day of COP.

1) Disability Benefits -

a. Generally during the short term (the first 45 days or less), and if the injury is a traumatic injury and certain other conditions are met, the employee receives “continuation of pay.”

b. If the employee’ medical disability appears that it is going to continue for at least 60 days, OWCP will place them on the periodic roll and will continue loss wage compensation through the date as supported by medical documentation.

c. Agency may compensate the employee for the difference in wages if OWCP determines medical evidence demonstrates the employee can perform duties of a lower paying job.

d. The employee's survivors also may receive death benefits.

2) Pay Rate - The pay rate or salary used to compute compensation benefits is the one in effect on Date of Injury, Date that disability begins, or Date of recurrence, whichever is greater.

a. 75% of employee's salary if the employee has dependents

b. 66-2/3% of employee's salary if there are no dependents

c. Workers' Compensation Benefits are Tax Free

3) Death Benefits - Survivors of federal employees whose death is work-related are entitled to benefits including compensation payments, funeral expenses, and transportation expenses for the remains. Survivors who are eligible for compensation are:

a. Widow/Widower

b. Unmarried child, under the age of 18; or, over the age of 18 if incapable of self support, due to mental or physical disability.

c. Child between 18-23, who has not completed four (4) years of post high school education and is regularly, enrolled in a **fulltime** course of study.

d. Parent, brother, sister, grandparent, or grandchild who was wholly or partially dependant on the deceased.

e. Compensation Payment Rates

- Surviving Spouse – No eligible children –
  50% of deceased's salary. Paid to spouse until death or remarriage if under age 55. If spouse is under 55 and remarries, OWCP makes lump sum payments equal to twenty four (24) times the monthly compensation at the time of remarriage. Remarriage after 55 does not affect benefits.
- Surviving Spouse who has eligible children -
  45% of the deceased's salary – Additional 15% is payable for each child up to a maximum of 75% of the deceased's salary.

- No spouse, with children -

1st child is entitled to 40% and each additional child is entitled to 15% of deceased salary to a maximum of 75%.

- No spouse no children -
  May be entitled to various percentages of the deceased salary by FECA according to degree of dependents.

f. Burial and Funeral Expense – A maximum of $800 may be paid for burial and funeral expenses. If employee's death occurs away from their area of residence, transporting costs of the body to the place of burial or cremation will be paid in full. An additional $200 allowance will be paid.

g. Death Gratuity - If applicable, a death gratuity for Federal employees (and employees of non appropriated fund instrumentalities) authorizes the United States to pay up to $100,000.00 to the survivors of "an employee who dies of injuries incurred in connection with the employee's service with an Armed Force in a contingency operation".

4) Scheduled Awards - Compensation is provided for permanent loss or loss of use of specified member, functions and organs of the body, for specific periods of time, once employee has reached maximum medical improvement, determined by treating physician. Compensation Scheduled is available at http://www.dol.gov/esa/owcp/dfec/regs/compliance/DFECfolio/agencyhb.pdf. Permanent impairment of the brain, heart, or back is excluded from schedule award consideration under the FECA. However, if an employee suffers such impairment, the employee may be compensated as if it were a total disability. To file a claim for a Scheduled Award, you must submit a Form CA-7, Claim for Compensation, or by a narrative letter and medical documentation. Scheduled Awards can be paid even if the employee has returned to work; however, employees may not receive wage loss compensation and a scheduled award concurrently for the same injury.

5) Disfigurement – If a work related injury results in a disfigurement to the face, head, or neck, FECA provides for an award of compensation not to exceed $3500, if the disfigurement will likely be a handicap in maintaining or securing employment.

6) Attendance Allowance – If the employee is unable to care for their physical needs, such as feeding, bathing, or dressing, an attendance allowance of up to $1500 per month may be paid. Attendants must be certified.

7) **House and Vehicular Modifications –** If an injury severally restricts mobility, independence and functions of living for either a prolong period or permanently, they may be entitled to house or vehicular modifications.

8) **Dual Benefits –** FECA prohibits payments of compensation and certain Federal benefits at the same time. However, you are not prohibited from filing for benefits from more than one (1) Government program at one time.

   a. Office of Personnel Management (OPM) - At the same time filing for FECA benefits you should also apply for OPM Annuities. However, you will be prohibited from receiving both OPM and OWCP at the same time.

   b. Department of Veteran Affairs (VA) - If you are entitled to OWCP compensation and VA benefits, you may need to elect between the two, if the disability or death resulted from an injury sustained in Federal civilian employment in certain instances.

   c. Social Security – You may receive OWCP compensation and Social Security benefits at the same time subject to income limitations by the Social Security Administration.

   d. Other Federal Income – You may receive OWCP compensation concurrently with retirement pay, retainer pay, military retired pay, equivalent pay in the Armed Forces or other uniform services subject to reduction of such pay in accordance with 5 U.S.C 5532(b)

   - **Severance Pay** may be received concurrently with OWCP compensation with a scheduled award or loss in wage earning capacity, but not with compensation for a total temporary total disability. However, separation pay may constitute a dual benefit and the agency should contact OWCP for further guidance.
   - **Unemployment Compensation** may be received concurrently with OWCP benefits.

9) **Computing Compensation –** Loss wage Compensation is based on a percentage of the employee's salary (or a statutory pay rate). Checks may be sent to a financial institution or a beneficiary, which they may designate, but they may not be sent in care of the employee's representative unless conservatorship or guardianship is established.

a. The pay rate for both disability and death claims to compute payments is the pay that is in effect on the date of injury, date of recurrence, or date disability begins, whichever is higher.

b. Additional pay included in salary, reported by the supervisor are:

- Night Shift
- Sunday Differential
- Hazard Pay
- Holiday Pay
- Dirty Work Pay
- Quarters Allowance
- Post Differential (Overseas employees)
- Extra pay authorized by the Fair Labor Standards Act (FLSA) for employees who receive annual premium pay for standby duty and who also earn and use leave on the basis of their entire tour of duty, including periods of standby duty.
- Overtime pay included for administratively uncontrollable work covered under 5 U.S.C. 5545©2).

c. Compensation Rate -

- 75% of employee's salary if the employee has dependents
- 66-2/3% of employee's salary if there are no dependents
- Workers' Compensation Benefits are Tax Free

d. Cost-of-Living Increases – Increases in the cost of living for the preceding calendar year is determined each March 1st. In order to receive cost of living increases you had to be entitled to compensation for at least one year before March 1st.

H. Leave Buy-Back

Leave repurchase is an entitlement for compensation purposes. It is computed the same way as compensation for loss of wages. Because leave is paid at 100%, the employee has the responsibility of repaying the agency for any additional cost of the repurchased leave.

I. Nurse Services

1) OWCP – Registered Nurses (RNs) under contract meet with employees, physicians, and agency representatives, ensuring proper medical care is being provided and to assist employees in returning to work.

2) AGENCY– OWCP RNs may coordinate care with agency nurse.

J. Vocational Rehabilitation Services

1) FECA provides vocational rehabilitation services to assist employees in returning to gainful employment within their physical, emotional, and educational abilities. Attending physician can also request rehabilitation services for those with extended disabilities, along with OWCP, when agency cannot reemploy the employee.

- Rehabilitation Counselors develop plans to include selective placement with previous employer, new employer, counseling, guidance, testing, work evaluations, training, and job follow-up.
- Once plan is completed, employee is given 90 days placement suspense to find a job.
- OWCP may determine employee's wage-earning capacity on the basis of a position which the medical evidence indicates employee can perform once the 90 day placement suspense is reached..
- Should employee refuse to participate in Rehabilitation Program or refuse to make a good faith effort to obtain reemployment, OWCP may reduce or terminate compensation depending on the circumstances of the refusal. OWCP will issue a formal decision, including appeal rights.

2) Assisted Reemployment – OWCP Program for Agency's that have had a difficult time in placing injured employees back to work. OWCP may reimburse an employer who was not the employer at the time of injury for part of the salary of a reemployed worker.

1) It is available to Federal employers as well as to State and local governments and the private sector.

2) The rate for reimbursement may not exceed 75 percent of the employee's gross wage.

3) Salary reimbursement may extend for up to 36 continuous months, but will not continue if reimbursement period is interrupted by a recurrence of disability due to the accepted condition.

4) The subsidy may not be transferred from one employer to another.

K. Federal Employees' Health Benefits (FEHB) and Optional Life Insurance (OLI) -

Deductions for FEHB and OLI coverage is deducted by OWCP if entitled.

1) **FEHB -** Compensation must be for at least 28 days for deductions to be made.

   a. **Disability -** Employee was enrolled in FEHB at the time of injury, plan will continue while compensating is being paid.

   b. **Death –** FEHB may continue for the surviving family members if the deceased was enrolled in self and family at the time of death and at least one covered family member receives compensation as a surviving beneficiary under FECA.

   c. **Transfer –** If the employee will be on OWCP for more than six (6) months, agency will transfer FEHB enrollment to OWCP. When employee returns employee to duty, OWCP will transfer FEHB back to the agency. If employee elects an annuity from OPM, OWCP will transfer enrollment to OPM. Changes in FEHB may be made during "open-season" each year with OWCP.

2) **OLI –** For the first 12 months when receiving compensation, OWCP will deduct the employee's portion of their FEGLI premium from their compensation check. If compensation is for more than one (1) year employee will have the option to convert to a private policy.

L. LEAVE –

Annual Leave and Sick Leave are not accrued while receiving compensation. Unused over-ceiling annual leave (over 240 hours per leave year) will be permanently forfeited unless specific conditions are met. The leave must be scheduled and approved in writing before the start of the 3rd biweekly pay period prior to the end of the leave year (mid-November). The employee can then submit a request through their manager/supervisor stating they were incapacitated for the scheduled leave period and were unable to reschedule.

M. Retirement Contributions –

CSRS and FERS Contributions are suspended while receiving compensation.

N. Thrift Savings Plan –

TSP Contributions and Loan Payments are suspended while receiving compensation.

O. Miscellaneous Deductions -

Payments for union dues, child support, alimony, and any similarly established deductions remain the responsibility of the employee.

P. Credible Service

Employees, under 5 U.S.C. 8151, who recovers within one (1) year of starting compensation, have mandatory retention rights to either old position or its equivalent, regardless of whether they are still on the agency rolls or not. If full recovery occurs, or partially recovery, they are entitled to priority consideration, as long as application is made within 30 days of the date compensation ceases. The regulations on retention rights are contained in 5 CFR 353, 302, and 330. and are administered by OPM, not OWCP.

1) **Retirement:** The period an employee receives compensation counts toward their retirement service date. When Returned To Work (RTW) in the Federal government, depending upon separation conditions, the time on the OWCP rolls will be credited upon the following conditions:

   a. **Compensationer:** No Annuity

   b. **Re-Employed Annuitant:** Approved Annuity

Agency should counsel employee upon retirement that "OWCP is not a retirement system". File for OPM benefits within one (1) year of agency separation. If you withdraw your contributions and you do not die from your accepted condition with OWCP, your beneficiaries will not be entitled to OWCP or OPM benefits.

2) **Service Computation Date (SCD) -** The period an employee receives compensation counts toward the SCD for leave.

3) **Within Grade Increase Date -** The waiting periods for within grade increases remain the same; however, the employee will not receive within grade increases until they return to duty.

7. REEMPLOYMENT

7. REEMPLOYMENT

When injured employee's medical evidence shows condition has either ended or employee can return to work (RTW) in light or limited duty who can work four (4) or more hours a day, (Agency) is encouraged to bring employee back to work, giving employee hope in their future when reemployment is an agency consideration. Employee is expected to accept the offer, in accordance with (IAW) 5 U.S.C. 8106. Offer should be compatible within medical restrictions of job related injury and including any non-related medical conditions.

Regardless of how long employees have received compensation, the following procedures apply when considering job offers:

A. Medical Evidence

1) Current medical documentation with medical limitations within 6 months.

2) If not current, request OWCP to request current/updated medical restrictions from treating physician.

B. Job Offer Elements

There are two (2) types of recovery when job offer is being considered and agency must keep position available for entire time of offer:

1) If employee is expected to RTW to job held at time of injury. The job offer elements to be considered are:

a. Position held at time of injury, modified with medical limitations.

b. Another Position at same salary as position held at time of injury.

c. Position at lower salary than position held at time of injury. If this is the case, employee is entitled to any loss wage compensation by OWCP.

2) If employee has not RTW for more than one (1) year, the job offer should include:

a. Description of duties to be performed.

b. Medical restrictions, with any special demands.

c. Organizational and geographical location of job.

d. Date on which job will be available (Start Date).

e. Date by which a response to the job offer is required.

f. Relocation Expenses – Must be included in offer, if applicable.

20 CFR 10.508, injured employee who relocates to accept a suitable job offer after termination from agency rolls may receive payment or reimbursement of moving expenses from the compensation fund. Former employees who move voluntarily and are offered reemployments at their former installations are generally not entitled to payment of relocation expenses. Eligibility – distance between the two locations must be at least 50 miles and the job must be medically and vocationally suitable. OWCP will make suitability decision of job offer. However, the regulations state specifically that "the agency may offer suitable employment at the employee's former duty station or other location" and that relocation expenses will be payable in either case.

3) Employee Acceptance/Declination Statement

4) Offer must be made in writing and sent to employee:

a. Return Receipt Requested, and by,

b. Regular Mail

5) Copy of offer sent to OWCP at same time being sent to employee.

C. Employee's Response

Agency should provide to OWCP when in receipt.

1) Acceptance – Employee accepts job offer.

2) No Response – OWCP considers same as refusal of job offer and will terminate benefits and issue a formal decision.

3) Refusal with No Explanation – Employee refuses job offer with no explanation, OWCP will terminate benefits and issue a formal decision.

4) Refusal with Explanation – OWCP will evaluate employee's reason for refusal of job offer and determine if reasonable cause has been show.

If so, agency will be notified and employee's compensation will continue while decision is being made. If not, OWCP will advise employee and allow additional 15 days to RTW. If employee doesn't RTW, OWCP will terminate benefits and issue a formal decision.

D. Job Suitability -

OWCP determines if Job Offer is suitable.

1) OWCP will notify employee, in writing, that they are expected to accept job or show reasonable cause for refusal

2) OWCP will advice employee that failure to accept job or to respond within 30 days will result in termination of compensation payments.

E. Temporary Job Offers

There is only one condition that agency can offer a Temporary Job to an injured employee:

1) Employee was a temporary employee at time of injury.

2) Did not RTW prior to Temporary Appointment ending.

3) Offer must be for 90 days.

F. Separation from Employment –

1) Reduction in Force (RIF) - Employee status with established wage-earning capacity does not change if RIF is across the board.

2) Removal for Cause – If employee is separated for misconduct and whose removal is wholly unconnected to the work-related injury employee is not entitled to further compensation benefits.

8. RECORDS MANAGEMENT

8. RECORDS MANAGEMENT –

Basic responsibilities of employees, managers/supervisors and agency injury compensation specialist.

A. Employees

1) Report **every** injury to your manager/supervisor and then follow the procedures set forth in the section below on Filing OWCP Claims. Submit all required documentation to OWCP and upon request within time requirements.

2) Return to work as soon as your doctor allows you to do so. If light duty is appropriate as the result of your injury, your employing agency representative, i.e., the person assigned by your region or office to handle OWCP claims, should provide you a copy of your job description and a Duty Status Report, CA-17 to provide to your physician so he/she can determine what work, including what light duty work, you can perform.

3) If your agency provides you with a written description of light duty work, you must provide a copy to your physician and ask if and when you may perform the duties as described.

4) If your treating physician recommends MRI, physical therapy, surgery, or any other medical treatment, it must be authorized by OWCP prior to receiving treatment. If an employee does not receive prior authorization, they may be responsible for expenses incurred.

5) Employee – Burden of Proof.

- Establishing facts/elements of claim
- Timeliness

6) Accountability:

- Comply with all safety regulations.
- Stop all unsafe acts
- Keep emergency data current

7) Communication:

- Treating Physician – ACS Payment information and authorizations
- Medical Providers - ACS Bill Payment information authorizations
- Supervisor
- Injury Compensation Specialists
- OWCP

B. MANAGERS/SUPERVISORS

Case Management begins when injury occurs.

1) Insure all OWCP and Agency Regulations and Policy's are current.

2) Checklist for Filing Claims When an Injury Occurs (See Appendix).

a. Advise employees on rights and responsibilities.

b. Complete the supervisor's portion of the required form and submit forms to OWCP in a timely manner:

- Notice of Injury Form - Form CA-1, or Notice of Occupational Disease Form CA-2, whichever form is appropriate, within 10 workdays of receipt from employee.
- Wage Loss/Permanent Impairment – Form CA-7 within 5 workdays of receipt from employee.

c. If the employee has suffered a traumatic injury, authorize COP immediately, if appropriate, and inform employee of right to elect continuation of regular pay (COP), or annual or sick leave if time loss will occur.

d. If the employee suffers from an occupational illness or disease, inform the employee of the need to complete Form CA-2 "Notice of Occupational Disease and Claim for Compensation." In addition to the completed CA-2, the employee, in coordination with the employer, must provide the completed applicable CA-35, "Evidence Required to Support a Claim for Occupational Disease," information and all medical reports applicable to claim.

e. If the employee suffered a traumatic injury, authorize medical care if needed, including complete the Medical Treatment Form CA-16. For a traumatic injury, the CA-16 should be issued within 4 hours of the request. Retroactive issuance of CA-16 is not permitted and should be kept in a protected area. If the employee suffers from an occupational disease, contact OWCP and obtain authorization prior to issuing a Form CA-16.

f. Assist employees in lifetime of claim and returning to work.

g. Represent the agency's interest.

h. Challenge questionable claims upon submission of initial claim to OWCP. If not in receipt of all documentation, annotate on claim, "additional information is going to be submitted".

i. Keep in contact with employees.

j. Manage the compensation costs.

k. Provide "light duty work" when able. Light Duty work is temporary work duties that meet the physical restrictions established by medical evidence. The work can be a modification of the employee's current position or other meaningful work duties that the employer may assign on a short term, temporary basis.

3) Tracking COP (See Appendix)

4) Communication

- Employee
- Injury Compensation Specialists
- OWCP

C. AGENCY INJURY COMPENSATION SPECIALIST

1) When an Injury Occurs**:**

a. Assist and advise Managers/Supervisors on employee's rights.

b. Assist Mangers/Supervisor filing, completion of all forms associated with claims.

c. Log claim in agency system (See Appendix).

d. Create Agency Claim File.

e. Review claim for accuracy.

f. If applicable, Controvert COP and/or Challenge Claim @ time of submission, if possible.

g. Timely Submission of claim to OWCP.

h. Was CA-16 issued?

i. Did employee seek medical care?

j. Did employee return to work?

k. Create COP Log (See Appendix).

l. Verify Medical Providers ACS enrollment (See Appendix).

m. If required, Notify Safety and Health Managers.

n. If applicable, submit claim electronically.

o. When claim number is received, notify supervisor.

p. Notify medical provider of agency Light Duty Accommodations (See Appendix).

q. Advise supervisor of agency Light Duty requirement.

r. When injury goes beyond COP, go to Intensive case Management.

2) Intensive Case Management

- Tracking and Reporting.
- Supervisor/Employee Training
- Working Group and partner with Safety and Occupational Health
- Administration
- Documentation
- Medical Information
- Reemployment
- Monitor Chargeback billings, Errors: Review Report Errors to OWCP
- Record Keeping:
  - Documents in Employee Medical Folder
  - OWCP Case File

3) Communication:

- Supervisor
- Employee
- OWCP
- Treating Physician – When applicable
- Medical Providers – When applicable

D. Contacting OWCP

1) Agency Query System (AQS) –Contains current case status, compensation payments, and medical bill payments for all active compensation cases.

2) Interactive Voice Response (IVR) - Provides agency with information about submitting medical bills for reimbursement and filing claims, and other case specific information.

3) Telephone – District OWCP Offices Representatives and Claims Examiners.

4) Agency is provided copies of all correspondence to employees, even when they are no longer on agency rolls. Agency may not use copies of information from claim files in connection with EEO complaints, disciplinary actions, or other administrative actions without employee's consent.

5) Agency requests to OWCP should be in writing with reason for requesting information.

6) Agency may review employee's OWCP file at District Office. Requests must be given in advance of the case reviews to be reviewed, along with the purpose.

8) Contractors – Agency should contact the OWCP National Office in writing to obtain approval for designation of private agency contractor.

E. FECA Penalties

Crime to file a false or fraudulent claim or statement.

1) Knowingly and willfully falsifies

2) Conceals

3) Covers up a material fact may be subject to these penalties.

- $10,000.00
- 5 Years Imprisonment
- Both

9. APPENDIX A.

CA FORMS

CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
CA-2	Notice of Occupational Disease and Claim for Compensation
CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
CA-5	Claim for Compensation by Widow, Widower and/or Children
CA-5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents or Grandchildren
CA-6	Official Superior's Report of Employee's Death
CA-7	Claim for Compensation on Account of Traumatic Injury or Occupational Diseases
CA-7a	Time Analysis Form
CA-7b	Leave Buy-Back (LBB) Work-sheet/Certification and Election
CA-16	Authorization for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report (Attached to Form CA-7)
CA-35, a-h	Occupational Disease Checklists
CA-2231	Claim for Reimbursement Assisted Reemployment
OWCP-5c	Work Capacity Evaluation
OWCP-915	Claim for Medical Reimbursement
OWCP-957	Medical Travel Refund Request

OWCP FORM 1500

Death Gratuity

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 ☐ Male ☐ 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
☐ Wife, Husband
☐ Children under 18 years
☐ 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 ☐ a.m. ☐ 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:

☐ a. 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.

☐ b. 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: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ 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: ☐ a.m. ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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-66-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 continue's 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.)

*U.S. GPO: 1999-454-845/12704

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)

8. Dependents
- ☐ Wife, Husband
- ☐ Children under 18 years
- ☐ 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)

11. 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 I 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.

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

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: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

24. First date medical care received Mo. Day Yr.

25. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ p.m.

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? ☐ Yes ☐ 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

Disability 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 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 off ice, 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 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 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.

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 Explanation: 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).

19. Agency name and address of reporting office

The name and address of the off ice 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.

24. First date medical care received

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

32. Employee's Retirement Coverage.

Indicate which retirement system the employee is covered under.

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.

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.

• U.S. GPO: 2001480-204/59062

Reset Print

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 ☐ Male ☐ Female
6. Home telephone
7. Home mailing address (include city, state, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ 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)
    - ☐ Medical Treatment Only
    - ☐ 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)

ZIP Code

27. Date of first return to FULL- TIME REGULAR duty following original injury
Mo. Day Yr.

28. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ 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 ☐ a.m. ☐ p.m.

33. Date pay stopped after recurrence Mo. Day Yr.

34. Dates COP paid for recurrence From Mo. Day Yr. To

35. Date returned to work after recurrence Mo. Day Yr. Time ☐ a.m. ☐ p.m.

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☐ No

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? ☐ Yes ☐ 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)

• U.S. GPO: 2000-467-602/39549

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 now 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.

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. ☐ Male ☐ 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) ☐ AM cl PM	11. Date and Hour of Death (Mo., day, year) ☐ AM ☐ PM	12. Date and Hour Employee's Pay Stopped (Mo., day, year) ☐ AM ☐ PM

13. Describe how injury occurred	14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ 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 positron held at time of injury for a full eleven months immediately prior to the injury? yes ☐ 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 OWCP use - NOI code
23. Did employee receive continuation of pay (COP) during perrod pnor to death? a. Pay rate used for COP $ per b. Inclusive dates of cop From To	24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:

25. Show date through which HBS deductions were last made (Mo., day, year)	26. Identify employee's Federal Retirement Plan: ☐ CSBS ☐ FERS ☐ 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 Servides 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? ☐ Yes ☐ 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-l, 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.

Reset Print

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

d. Date of Injury Month Day Year

e. Social Security Number

E-Mail Address (*Optional*)

f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

Inclusive Date Range From To

Intermittent?

a. ☐ Leave without pay — ☐ Yes ☐ No *Go to Section 3*

b. ☐ Leave buy back — ☐ Yes ☐ No *Go to Section 3, and Complete Form CA-7b*

c. ☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type: — ☐ Yes ☐ No *Go to Section 3*

If intermittent, complete Form CA-7a, Time Analysis Sheet

d. ☐ Schedule Award (*Go to Section 4)*

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
				☐	☐
				☐	☐
				☐	☐

For dependents not living with you, complete items a and b below.

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? ☐ Yes ☐ 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?

☐ Yes ☐ No — Claim Number | Full Address of VA Office Where Claim Filed | Nature of Disability and Monthly Payment

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

☐ Yes ☐ No — Claim Number | Date Annuity Began | Amount of Monthly Payment | Retirement System (CSRS, FERS, SSA, Other) ☐ CSRS ☐ FERS ☐ SSA ☐ Other

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

Date of Injury:	Base Pay	Additional Pay	Additional Pay	Additional Pay
Date: _____	$_____ per _____	Type _____ $ _____ per _____	Type _____ $ _____ per _____	Type _____ $ _____ 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 (SUB), Quarter (QTR), etc. (List each separately)

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? 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 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-Z only)*

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:

		Intermittent?	
Sick Leave From _____	To _____	☐ Yes	☐ No
Annual Leave From _____	To _____	☐ Yes	☐ No
Leave without Pay From _____	To _____	☐ Yes	☐ No
Work From _____	To _____	☐ Yes	☐ No

If intermittent, complete Form CA-7a, Time Analysis Sheet.

If leave buy back, also submit completed Form CA-7b.

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 ___/___/___
(Agency Official)

Name of Agency _____

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 quality 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:

Section Number	Explanation
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-lime 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. It 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

What Does the CA-16 Cover? (excerpt from Dept. of Labor website)

A CA-16 is a form given to a claimant by his or her agency that acts as a contract between our office and health care providers. This form guarantees payment of all non-invasive procedures for 60 days after a traumatic work-related injury. The doctor chosen (via a CA-16 or referral) is referred to as the "attending physician of record."

The CA-16 will cover all non-invasive procedures including:	The CA-16 will not cover:
• Diagnostic imaging studies (x-ray, MRI, etc.) • Office/ER visits (including follow-up) • Braces, splints, casts, canes, and TENS units • Prescriptions • Physical Therapy • Hospitalization	• Surgery • Home Exercise Equipment, Whirlpools, or Mattresses • Spa/Gym Membership • Work Hardening Programs

Can the CA-16 apply to more than one doctor?

Yes. For instance, if the patient is referred from one physician to another or to an imaging center or physical therapist, the same CA-16 originally issued to the referring physician can be used to authorize these services.

When I send bills in, should I include a copy of the CA-16?

Although it is not required, it can be helpful. And remember, to save yourself some needless paperwork:

- Call the employer and ask for the patient's OWCP case number
- Put the case number on each bill you submit
- If a case number is not available yet, tell the patient to contact you when one is issued - DO NOT SUBMIT BILLS WITHOUT A CASE NUMBER - THEY WILL BE RETURNED.

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)
☐ Yes ☐ 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? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ 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
☐ Light Work Date:
☐ 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 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.

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

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item 8. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM)

Information for Physician – See Reverse Side

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

This form covers office visits and consultations, laboratory work, hospital services (including inpatient), x-rays, MRIs, CT scans, physical therapy, emergency services (including surgery) and chiropractic services. Chiropractic services are limited to charges for physical examinations and x-rays to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

This form does not cover elective and non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym membership and work hardening programs.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 39, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409, OWCP-1500, or HCFA-1500). Each procedure must be identified. In Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.
- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identified in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN – either corporate or personal – which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

★ U.S. GPO: 1999-454-845/92710

Duty Status Report

Reset Print

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

1. Employee's Name (Last, first, middle)
2. Date of Injury (Month, day, yr.)
3. Social Security No.
4. Occupation
5. Describe How the Injury Occurred and State Parts of the Body Affected
6. The Employee Works
   Hours Per Day ____ Days Per Week ____
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.

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)
9. Description of Clinical Findings
10. Diagnosis Due to Injury
11. Other Disabling Conditions
12. Employee Advised to Resume Work?
    ☐ Yes, Date Advised ____ ☐ No
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 #lbs.	Intermittent #lbs.	Hrs Per Day	Continuous #lbs.	Intermittent #lbs.	Hrs Per Day
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

t. Other (Describe)

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.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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G. P. 0. - 2000 - 188-099

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	✓
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.	
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.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.	
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.	

FROM EMPLOYING AGENCY	✓
5. Review and comment on employee's statement provided in response to Item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
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.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identity what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

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	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.	
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.	
3. Give history of any previous ear or hearing problems.	
4. Describe any hobbies which involve exposure to loud noise.	
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.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the employee's statement in response to questions 1-5.	
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.	
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.	
12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensatiion benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees Notice of Occupational Disease and Claim for Comeprisation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

Evidence Required in Support of A Claim for Asbestos-Related Illness

U.S. Department of Labor
Employment 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	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service **(see attached questionnaire.)**	
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 per week exposed, and the types and frequency of safety precautions (mask, respirator, etc.) used **(see attached questionnaire).**	
3. Describe any exposure you have had to other toxic substances. If none, state "None".	
4. Describe any breathing or lung problems you have had in the past and treatment received **(see attached questionnaire)**.	
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 similar condition or pulmonary problem.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
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)**.	
11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
12. Attach copies of the employee's: a. SF-1 71, Application for Employment. b. Position description with physical requirements for last job hold. c. Job shoot 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.	
13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

PART A TO BE COMPLETED BY CLAIMANT

In order to determine if you are eligible for benefits, please provide the following information using your best estimates. If you run out of space, use a separate piece of paper and attach it to this form. Submit the form to your current (or last) employing agency. If the facility is no longer active, submit the statement to OWCP.

I. Employment History: Please include all employers, both Federal and non-Federal, your job titles, the work you performed, and the period you held each job. (Include military service).

Employer (Agency)	Job Title	Work Performed	Period	Fed. Civil Service? (Yes/No)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

II. Exposure History: Please describe all exposure to asbestos and other toxic materials in your employment. Include period of employment, type of exposure, number of hours exposed per workday and description of safety precautions used while working.

a. **Asbestos:** For "type of exposure" indicate whether exposure was heavy, medium or light:

Heavy - Visible airborne asbestos particles were evident.

Medium - Asbestos dust was visible on floors and work surfaces.

Light - No dust visible, but asbestos was in use.

Period	Type of Exposure (H, M, L)	Exposure Hrs/Day	Safety Precautions Used
1.			
2.			
3.			
4.			
5.			

b. Toxic Chemicals/Dust

Period	Material Exposed to:	Exposure Hrs/Day	Safety Precautions Used
1.			
2.			
3.			
4.			
5.			

(PLEASE CONTINUE ON REVERSE SIDE)

Notice to Employees Filing Claim for Occupational Disease

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employee's Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

Notice to Compensation Specialists and Supervisors

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required-in support of the claim. One checklist is for the employee to mark and return with the complete package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

III. Medical History: Describe your medical history and include any treatment for heart, lung and other major health problems.

Have you ever had:	Yes	No	If Yes, explain	Dates
1. Heart Problems?				
2. Lung Problems?				
3. Other Major Problems?				

IV. Smoking History: Describe your smoking history, including dates you smoked, amount of material smoked per day, and type of material smoked.

Have you ever smoked:	Yes	No	If Yes, amount	No. of years	Date stopped	Dates
1. Cigarettes?						
2. Pipe?						
3. Cigars?						

PART B TO BE COMPLETED BY EMPLOYING AGENCY

Using the categories shown below, please complete the chart at the bottom of the page with reference to each Federal job hold by this employee.

a. Nature of Exposure:

Primary - Normal duties required actual manipulation of asbestos and/or asbestos-related products and generated dust.

Secondary - Normal duties regularly involved work alongside others primarily exposed or in confined spaces.

Intermittent - Normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated.

Environmental - Normal duties were performed at a location where asbestos was used but the individual had no normal exposure in excess of ambient levels.

b. Degree of Exposure:

Heavy - Asbestos dust was usually visible in the air.

Medium - Asbestos dust was generally visible on work surfaces but did not cloud the air.

Light - Asbestos was used in work area but was generally not visible (although detectable).

Ambient - Asbestos levels did not exceed normal levels In the air outside of work spaces.

c. Frequency of Exposure: Hours per day.

Job Title	Period		Asbestos Exposure			Other Chemical or Dust Exposure				
	From	To	Nature	Degree	Frequency	Material	Nature	Degree	Frequency	Fiber/cc
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										

*U.S. Government Printing Office: 1989-229-460/99190

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	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
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.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
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.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements in response to questions 1-5.	
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.	
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.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
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.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed to let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements, and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

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	✓
1. Give a detailed description of employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.	
3. Describe any previous skin conditions from the time they began through the present.	
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: 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.	

FROM EMPLOYING AGENCY	✓
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.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: 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.	

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	✓
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.	
2. Explain the development of the present pulmonary condition and treatment from its beginning.	
3. Give your smoking history to include amounts and years (dates) you smoked.	
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.	

FROM EMPLOYING AGENCY	✓
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?	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
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.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

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If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2. Federal Employees Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence from the employee, the checklists describe the information to be submitted to by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

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	✓
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2. Describe the progress and development of the work-related condition from its beginning.	
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.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✓
7. Review and comment on the employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
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.	
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.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
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.	

MEDICAL REPORT FOR PSYCHIATRIC CLAIM

You should submit a medical report from your physician which includes:

a. History of onset of illness.
b. Social and family history.
c. Detailed description of your work situation and identification of the specific work factors contributing to your emotional or psychiatric condition.
d. Review of any non-industrial stress situations.
e. Mental status examination, with pertinent findings.
f. Results of psychological and personality testing.
g. Diagnosis according to DSM III.
h. Clinical course of treatment followed.
i. Prognosis with estimate of when you will be able to return to work.
j. Physician's opinion, with reasons for such opinion, as to whether, how and which factors of your employment caused, aggravated, precipitated, or accelerated your disability.
k. An assessment of your current condition, with specific details on how you can or cannot function in daily activities, including a discussion of any limitations you may have in your ability to give or take supervision, cooperate with others, work under deadlines, or any other pertinent factors which may effect your work capacity.

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition, to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

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;

b. Complete medical history of condition;

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;

e. Treatment to date and prognosis;

f. Reasoned opinion explaining any causal relationship between the condition and your Federal civilian job.

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.

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

Form CA-35H
October 1987

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

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We appreciate your cooperation in this effort.

Submit | Reset | Print

ME-OW

Work Capacity Evaluation
Cardiovascular/Pulmonary Conditions

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

Injured Worker's Name (*First, middle, last*) *	OWCP No. *	OMB No: 1215-0103 Expires: 08/31/2005

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1.a. Is this employee capable of performing his/her usual job? ☐ Yes ☐ No. If no, is **prevention** (of possible future injury) the **only reason** for work limitations? ☐ Yes ☐ No. **If prevention is not the only reason,** please explain your medical reason for limitations: *

Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work location.

b. If unable to perform his/her usual job, is the employee able to work for 8 hours per workday with restrictions?

c. If less than 8 hours per workday, how many hours can he/she work?

d. Do You anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

If yes, when will this person achieve an 8 hour workday?

If no, please provide medical reasons to support your opinion:

2. Has the work injury/condition caused **ANATOMICAL** and/or **FUNCTIONAL** changes in the cardiovascular or respiratory systems that preclude exposure to: *

a. Temperature extremes	☐ Yes	☐ No	c. Gas/fumes	☐ Yes	☐ No
b. Airborne particles	☐ Yes	☐ No	d. Electromagnetic radiation	☐ Yes	☐ No

3. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work	Activity	Limitation	# of Hours Able to Work	Lbs.
Sitting	☐ Yes		Pushing	☐ Yes		
Walking	☐ Yes		Pulling	☐ Yes		
Standing	☐ Yes		Lifting	☐ Yes		
Reaching	☐ Yes		Squatting	☐ Yes		
Bending	☐ Yes		Kneeling	☐ Yes		
Operating a Motor Vehicle	☐ Yes		Climbing	☐ Yes		

4. Is the person taking **MEDICATIONS** that impact the ability to work? Please explain. *

5. Are there OTHER medical factors, situational considerations (e.g., high volume work, shifting priorities), equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

6. Physician's Name (*Type or print*) *	7. Telephone *

8. Signature	Signature	9. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection 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 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, 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 THE OFFICE SHOWN ABOVE.

Claim for Medical Reimbursement

Reset Print

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

Provide all information requested below. **DO NOT FILL IN SHADED AREAS.** Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.

OMB No. 1215-0193
Expires: 03/31/2007

PERSONAL INFORMATION

Name

Last | First | M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City | State | Zip Code

Telephone Number

FOR DOL USE ONLY

PROVIDER INFORMATION

Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)

Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM, DD, YY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Total Reimbursement
$

I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.

Signature _____ Date _____

INSTRUCTIONS FOR USE OF FORM OWCP-915

- This form is to be used to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted condition. Form OWCP-915 can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies.
- Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your OWCP file number on all documentation. Maintain a copy of the completed OWCP-915 and supporting documentation for your records.

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed OWCP-915

2. A paper pharmacy billingform, which must be attached to the OWCP-915 and must include the following information:

    a. Name, address and telephone number of pharmacy
    b. Pharmacy provider number
    c. Prescription number
    d. Name of claimant
    e. Date of purchase
    f. Eleven Digit National Drug Code (NDC#)
    g. New prescription or refill number
    h. Quantity of medication (e.g. # of pills or ml/cc)
    i. Amount paid by employee per medication

3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Medical Expense other than prescription medication

1. Completed OWCP-915

2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-92. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount paid by the claimant must be indicated. The OWCP-1500 or OWCP-92 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed OWCP-1500 or OWCP-92 from the provider rendering service. *Without a fully completed OWCP-1500 or OWCP-92, the OWCP is not able to process a reimbursement.*

3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Travel

Do not use Form OWCP-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on Form OWCP-957.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to 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 S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

Medical Travel Refund Request

Reset | Print

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

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 108. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1215-0054
Expires: 06/30/2007

1. Claimant's Name (Last, First, Mi.):

2. Case/Claim Number:

3. Payee's Name if different from claimant's name (last, first, mi.): (See instruction no. 3 on the back of form)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code):

Special Instructions:
1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is **REQUIRED by BLACK LUNG** for verification of each service date and type.

5a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other
(Specify)

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

6a. Date of Travel:

b. ☐ One-way ☐ **Round Trip**

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other
(Specify)

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

7a. Date of Travel:

b. ☐ One-way ☐ Round Trip

c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home

e. Medical facility name and address

f. Total expense/cost
☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other
(Specify)

9. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only)
Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

8. **Payee's Certification:** I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

Claimant's/Payee's Signature: Date:

Form OWCP-957
Rev. Aug 2003

Instructions (Form OWCP-957)

1. Enter claimant's full name: last name, first name, middle initial.

2. Enter claimant's claim/case file number.

3. Enter payee's full name (if person other than the claimant is to be reimbursed): last name, first name, middle initial.
A payee other than the claimant must have special authorization.

Please explain the following:

a. Relationship to the claimant

b. The reason you are requesting reimbursement

---

4. Enter the address of the person to be reimbursed. The address is to include:
Street/RFD, City, State, Zip Code

5. 6, and 7. Complete a separate block for each medical facility visited on the same day. For travel on different days, complete one block for each date.

a. Enter date of travel.

b. Mark one box only.

c. Mark one box only.

d. Mark one box only.

e. Enter the name and address of the medical facility.

f. Mark each box for which you are claiming reimbursement and list the amount of money spent for each item.

g. Enter the total number of miles traveled by private automobile.

h. The physician or designee is to complete this item (for Black Lung use only).

8. The person claiming reimbursement must sign here.

Attach all original receipts for expenses listed in 5f, 6f, and 7f. The claimant's full name and Social Security Number should appear on each receipt.

FOR BLACK LUNG USE ONLY

Note:
- Only travel expenses for the miner are reimbursable
- Special approval from the district office is needed for lodging or for travel exceeding 75 miles one way or 150 miles roundtrip.
- To obtain your district office telephone number, call toll free 1-800-638-7072.
- Reimbursement for meals will be made only when authorized travel exceeds 24 hours or under special circumstances.
- Travel to pick up medicine, equipment or supplies in not reimbursable.

FOR ENERGY EMPLOYEES ONLY

Note: Special approval from the district office is needed for overnight or air travel, or for travel exceeding 100 miles one way or 200 miles roundtrip. To obtain your district office telephone number, call toll free 1-866-272-2682.

Public Burden Statement

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If 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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K 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 NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

APR 10 2008

David S. C. Chu
Chief Human Capitol Officer
Department of Defense
Office of Personnel and Readiness
Washington, D.C. 20301

Dear Mr. Chu:

This is to advise you that the Federal Employees' Compensation Act (FECA) was recently amended by adding a new section 8102a (5 U.S.C. § 8102a). (See section 1105 of the National Defense Authorization Act for FY 2008, Public Law 110-181) This new provision creates a death gratuity for federal employees (and employees of nonappropriated fund instrumentalities) by authorizing the United States to pay up to $100,000 to the survivors of "an employee who dies of injuries incurred in connection with the employee's service with an Armed Force in a contingency operation." Unlike other death gratuities, this death gratuity was placed within FECA and, for that reason, will be administered by the Department of Labor's Office of Workers' Compensation Programs (OWCP) as part of the FECA program.

This provision became effective on January 28, 2008, and OWCP is currently drafting regulations implementing the amendment. This one-time death gratuity is to be disburse to the survivors of the employee in a specific, and somewhat complicated, order of precedence set forth in the statute. It is important to note that these beneficiary stipulations are unique to this new provision, and no existing DOL rules or guidelines cover these circumstances.

The statute also provides the employee the opportunity to change the order of precedence in regard to certain survivors as well as designate up to 50 percent of th benefit to any person. Since the death gratuity is now in effect, DOL believes that it is imperative that potentially affected federal employees be provided the opportunity to exercise the designation option for any death gratuity that unfortunately may be payable

Therefore, OWCP has created a form, a copy of which is enclosed, to be used by employees to designate the distribution of the death gratuity, should one be payable. Th instructions accompanying the form explain the order of precedence that governs awarding the death gratuity and the optional designations that an employee can make. **No designation is necessary if an employee wishes any death gratuity to be distributed in accordance with the order of precedence set out in the statute.**

We recommend that any time a Federal employee is assigned to provide service to an Armed Force in a contingency operation, as defined in this provision, he or she be informed of this death gratuity and be given the opportunity to designate a beneficiary on the enclosed form. Employees already so assigned should also be given this opportunity. An employee desiring to designate one or more beneficiaries of a death gratuity payable under this provision should complete and sign a copy of this form, retain a copy, and give the original to his or her employer to be maintained by the employer in the employee's official personnel file, or a related system of records, in case it should be needed at any time in the future.

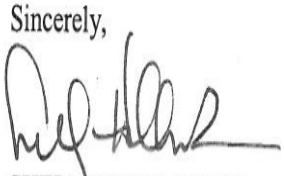
We recommend very strongly that an employee desiring to make a designation varying the order of precedence in the statute, or awarding some of the benefit to another person, utilize the form to avoid potential difficulties in discerning their intentions. However, we recognize that there will be exigent circumstances where this is not possible. In the event that the attached form is not utilized to make a desired designation, we will recognize any document specifying the beneficiary designation that an employee desires to make if it is both signed and dated by the employee and signed and dated by an official of the employing agency involved prior to the death of the employee. Employees not using the form should clearly specify any designation they wish to make.

Your assistance in disseminating this information and obtaining signed designation forms where warranted is vital to proper implementation of this statute, and I urge you to initiate this new procedure as soon as possible so that employees in harm's way have the benefit of this legal authority.

The Department of Labor is moving quickly to draft an interim final rule to provide formal guidance on this and other issues associated with the new provision, but your introduction of this beneficiary election process in advance of those regulations may prevent the loss of a gratuity that would otherwise be payable.

Please contact Barbara Williames of the Division of Federal Employees' Compensation at 202-693-0964 if you have questions about this matter.

Sincerely,



SHELBY HALLMARK
Director, OWCP

Enclosure

ACS

(Department of Labor, Federal Workers Compensation
Medical Bill Payment Information)

FEDERAL EMPLOYEES ARE COVERED BY THE U.S. DEPT OF LABOR, FEDERAL EMPLOYEES COMPENSATION ACT (FECA) FOR WORK-RELATED INJURIES.

Provider Enrollment Address:
Affiliated Computer Services (ACS) – Enrollment Unit
Department of Labor (DOL), P.O. Box 14600
Tallahassee, FL 32317- 4600
Fax: (850) 201-1718

_____Federal Workers Compensation Contact (ICPA):

Name_____
Phone_____

This card is provided for informational purposes only and is not a guarantee of payment (1 of 2)

ACS

Submit Medical Bills & Medical Documentation/Correspondence To:
U.S. Dept of Labor OWCP – Central Mailroom, P.O. Box 8300, London KY 40742-8300
Phone: (850) 558-1818 or (866) 335-8319 Toll Free IVR
ACS Authorization Fax # (800) 215-4901
ACS Website: http://owcp.dol.acs-inc.com

Prescription Benefit Inquiries: (866) 664-5581
ACS Help Desk For Providers: (800) 461-7485

Provider Checklist:
- Provider enrolled with ACS/ACS provider number on bill
- FECA Case # on medical bill & documentation
- Medical documentation submitted to the Department of Labor (DOL)
- Prior authorization requested
- Diagnosis code obtained from injured employee/copy of DOL letter

This card is provided for informational purposes only and is not a guarantee of payment (2 of 2)

CHEAT SHEETS

CA1
NOTICE OF TRAUMATIC INJURY AND
CLAIM FOR CONTINUATION OF PAY / COMPENSATION

CA2
NOTICE OF OCCUPATIONAL DISEASE
AND CLAIM FOR COMPENSATION

CA2a
NOTICE OF RECURRENCE

CA 5, 5b and 6
REPORT OF DEATH

NOTICE OF INJURY

CA1
NOTICE OF TRAUMATIC INJURY AND
CLAIM FOR CONTINUATION OF PAY / COMPENSATION

CLAIM

CA1 NOTICE OF INJURY

CA16 MEDICAL

C.O.P. - REPORTED WITHIN 30 DAYS OF INJURY

IF NOT

CA7 (A&B)

CA17

CA20

EVENT OR INCIDENT IN:

ONE SINGLE WORK SHIFT

IDENTIFIABLE BY TIME & PLACE AND MEMBER/FUNCTION OF BODY AFFECTED

TIME LIMITS:

3 YEARS FROM DATE OF INJURY

OCCUPATIONAL DISEASE

CA2
NOTICE OF OCCUPATIONAL DISEASE
AND CLAIM FOR COMPENSATION

CLAIM

CA2 NOTICE OF OCCUPATIONAL DISEASE

CA16 NO

NO C.O.P.

COMPENSATION

****CA7 (A&B)**

CA17

CA20

INCIDENT WITHIN:

TWO WORK SHIFTS

SYSTEMIC INFECTION, CONTINUED OR REPEATED STRESS/STRAIN;
EXPOSURE TO TOXINS, POISONS, FUMES, ETC, OR,
OTHER CONTINUED OR REPEATED EXPOSURE TO WORK CONDITIONS

TIME LIMITS:

3 YEARS FROM: DATE OF AWARENESS,
RELATIONSHIP TO EMPLOYMENT
LAST EXPOSURE

RECURRENCES

CA2a
NOTICE OF RECURRENCE

CLAIM

CA2a NOTICE OF RECURRENCE

CA16 NO
(1 PER INJURY)

C.O.P. IF: WITHIN 45 DAYS WINDOW
REMAINDER OF DAYS

COMPENSATION

****CA7 (A&B)**

CA17

CA20

NO INCIDENT CAUSES RECURRENCES. CLAIMANT CONTINUES TO SUFFER FROM ORIGINAL INJURY/DISEASE

NO TIME LIMITS:

WHEN PHYSICIAN HAS RELEASED CLAIMANT AND RECURRENCE OF EITHER INJURY/DISEASE REAPPEARS FOR NO APPARENT REASON

DEATH

CA 5, 5b and 6
REPORT OF DEATH

CLAIM

CA5

CA 5B

CA6

CA7 CLAIM FOR COMPENSATION

REPORT IMMEDIATELY TO HRO

APPOINT LIAISON TO ASSIST FAMILY

TIME LIMITS:

3 YEARS FROM DATE OF DEATH
3 YEARS FROM BENEFICIARY 1ST AWARE OF CAUSAL RELATIONSHIP

APPENDIX B.

AGENCY POLICY - *SAMPLES*

1. Light Duty
2. Reemployment
3. Leave Buy Back
4. Physical Training

APPENDIX C.

CONTINUATION OF PAY

1. Quick Guide for Calculating COP
2. COP Worksheet
3. COP Tracking Worksheet and Compensation Tracking Worksheet

Quick Guide for Calculating COP

1. **Count 30 days from the Date of Injury. The employee must submit the CA-1 to the employing Agency by this day to be eligible for COP. If the employee submits the form before this date then he/she meets the initial criteria to be eligible for COP. Once the employee meets this criteria disregard this date.**

2. Count 45 days from the Date of Injury. The employee must begin losing time by this date in order to be entitled to COP. Once the employee has lost time from work due to the injury and the time off occurred before this date, disregard this date it no longer has any effect on COP entitlement.

3. Once the employee returns to work for the first time following a period of disability after the injury, count 45 days from the date the employee first returned to work and that is the last date the employee has to use COP. This date will now drive COP entitlement.

   Example 1: An employee is injured and is off work on the date of injury and the following day. The employee returns on the third day. Count 45 days from the third day and that date will be the last day the employee can use COP.

   Example 2: An employee is injured and loses no time initially. Two weeks later, the employee is off work due to the injury for a period of 10 days. To establish the last day the employee is entitled to COP, count 45 days from the date the employee returned to work following the 10 days off. This is the first return to work following a period of disability the employee had since they did not lose time initially following the injury. This date will now govern COP entitlement.

Coding COP (Continuation of Pay) for lost time on time cards – code day of injury on time card: LU-Date of Traumatic Injury. Every day or partial day lost thereafter due to injury: LT-Traumatic Injury (COP). If one hour of COP is used, it counts as a whole day. If leave is taken in conjunction, code both separately, but COP still counts as a full day.

SAMPLE
COP Worksheet MI-L

Assumptions:
1. Traumatic injury with DOI of 1/4/99 or later.
2. Notice of injury was filed on form CA-1 (or form accepted as a CA1) within 30 days of injury.
3. Maximum COP payable in any case is 45 days total.
4. Full work day assumed for rtw date unless rtw same day
5. Employment did not terminate

Ref: PM Part 2, Chap 807.13

Enter data in yellow highlighted areas only.
This calculator can be used for three disability periods.

Today's Date: 8/28/2008

Claim Number:
Name:

		COP Used	COP To:
A. Date of Traumatic Injury (DOI)	=		
B. Was admin lv used on DOI and rtw on DOI or rtw full day following DOI? y or n			
C. 45 calendar days after DOI (see Note 1)			
D. 1st disability date (usually not DOI - see Note 2)			
E. Date returned to work after 1st disability, enter n if there was no return to work			Note 3
F. 45 calendar days after first return to duty			
G. 2nd disability date			
H. Date returned to work after 2nd disability, enter n if there was no return to work			
I. 3rd disability date			
J. Date returned to work after 3rd disability, enter n if there was no return to work			
		Tot COP =	

Note 1: COP may be payable beyond 45th day after DOI.
COP is payable up to 45 days after date first rtw following a work stoppage. Under certain circumstances, COP can be paid well beyond 90 days after DOI as long as 45 days is not exceeded (possibly up to 134 days after DOI).
Note 2: COP paid on DOI only when injury occurs before work begins.
Note 3: Continuing TTD assumed when there is not rtw ("n" entered)

INJURY COMPENSATION/COP WORKSHEET

1. **General Information** *Entitlement Period Ends*: _____

Name: _____ DOI: _____

Supervisor: _____ Phone: _____ Injury Type: _____

Work Week: S M T W T F S Duty Hours: _____ Pay: $____ per Hour/Annum (GS/WG)

Claim Accepted? Yes No COP Authorized: Yes No OWCP File: _____

SSAN: _____ Occupation: _____

Home Address: _____ Home Phone: _____

Attending Physician: _____ Address: _____ Phone: _____

2. **COP Log** (*RTW=Return to Work*) (LU=Date of Traumatic Injury) (LT=COP)

(COP) Days	Calendar Date	(COP) Hours	Remarks	(COP) Days	Calendar Date	(COP) Hours	Remarks
1				24			
2				25			
3				26			
4				27			
5				28			
6				29			
7				30			
8				31			
9				32			
10				33			
11				34			
12				35			
13				36			
14				37			
15				38			
16				39			
17				40			
18				41			
19				42			
20				43			
21				44			
22				45			
23				*Total*	*Hours: _*	_____	

1. **Compensation** SL and/or AL log (Start on 46th day; Also for Occupational Disease.)

1				9			
2				10			
3				11			
4				12			
5				13			
6				14			
7				15			
8				*Total*	*Hours:__*	_____	

APPENDIX D.

FECA APPEAL RIGHTS

1. **ORAL HEARING OR REVIEW**

   30 DAYS OF DECISION DATE

   RECONSIDERATION HAS NOT BEEN REQUESTED

2. **RECONSIDERATION**

   ONE YEAR OF DECISION DATE

   INFORMATION NOT PREVIOUS SUBMITTED

   ERROR IN LAW REACHING PREIVOUS DECISION

3. **APPEAL**

   EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)

   90 DAYS OF DECISION DATE

   HIGHEST FECA AUTHORITY

APPENDIX E.

REEMPLOYMENT

1. OWCP 5c Work Capacity Evaluation
2. Permanent Job Offer Sample
3. Temporary Job Offer Sample

ME-OW

Work Capacity Evaluation
Musculoskeletal Conditions

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

Injured Worker's Name (*First, middle, last*)	OWCP No.	OMB No: 1215-0103 Expires: 10-31-2008

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1a. Is the worker capable of performing his/her usual job? ☐ Yes ☐ No. If no, please explain.

Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his her usual job, is the claimant able to work for 8 hours per workday with restrictions? ☐ Yes ☐ No. If no, please provide medical reasons to support your opinion. _____

c. If less that 8 hour per workday, how many can he/she work? _____

d. Do you anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion

f. How long will the restrictions apply? _____

g. Has maximum medical improvement been reached? ☐ Yes ☐ No.

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work
Sitting	____ Yes	_____
Walking	____ Yes	_____
Standing	____ Yes	_____
Reaching	____ Yes	_____
Reaching above Shoulder	____ Yes	_____
Twisting	____ Yes	_____
Bending/Stooping	____ Yes	_____
Operating Motor Vehicle at work	____ Yes	_____
Operating a Motor Vehicle to/from work	____ Yes	_____

Activity	Limitation	# of Hours Able to Work	Lbs.
Repetitive Movements:			
Wrists	____ Yes	_____	
Elbow	____ Yes	_____	
Pushing	____ Yes	_____	____
Pulling	____ Yes	_____	____
Lifting	____ Yes	_____	____
Squatting	____ Yes	_____	____
Kneeling	____ Yes	_____	____
Climbing	____ Yes	_____	____
Breaks:			
Duration _____		Frequency _____	
Duration _____		Frequency _____	

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (*Type or print*)	5. Telephone
6. Signature	7. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection 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 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, 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 THE OFFICE SHOWN ABOVE.

Dr.
(Address)

Subject: Current Medical Restrictions Request
Claimant, Case Number,

Dear Dr.

The _____(Agency) _____ request that you complete the attached (Duty Status Report (Form CA-17) or Work Capacity Evaluation (OWCP 5c). The information you provide is vital to this agency to determine any physical limitations resulting from the injury for which you are treating our employee.

(Agency) is committed to accommodating our injured employees with suitable light duty work that is in strict compliance with their work restrictions. Light duty can be as sedentary as answering the telephone, filing, office work, etc., despite the physical requirements of the employee's regular position. Often the employee's regular position can be modified to comply with the work restrictions.
Thanking you in advance for taking time to assist your patient and us.

If you have any questions or concerns, please feel free to contact the undersigned at _____.

Sincerely,

Cf: OWCP
Claimant

(Letterhead) **(Current Date)**

(Date 3-5 Workdays)

Claimant
(Address)

Subject: Job Offer
Claimant, Case Number,

Dear (Claimant)

The following job is being offered to you. On (Date of Injury) you were injured with our agency. We requested your treating physician to complete attached current Duty Status Report (Form CA-17) Work Capacity Evaluation (OWCP 5c). (Agency) is committed to accommodating our injured employees with suitable work, that is in strict compliance with your work restrictions.

If you have any questions or concerns, please contact the undersigned at _____ .

Sincerely,

SEND: (1) CERTIFIED AND 2) REGULAR MAIL

2. or 3.

Letter Head

SUSPENSE DATE (3-5 Workdays)

CURRENT DATE: _____

MEMORANDUM FOR (CLAIMANT, ADDRESS)

SUBJECT: Permanent Return to Work Job Offer

1. The position being offered is in accordance with the Office of Workers' Compensation Programs, U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, Injury Compensation for Federal employees Publication CA 810, Revised January 1999.

SUBJECT: Temporary Return to Work Job Offer

1. The position being offered is in accordance with the Office of Workers' Compensation Programs, U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs, Injury Compensation for Federal employees Publication CA 810, Revised January 1999.

2. or 3.

"A temporary position may be offered only to a worker who held a temporary position when injured, and if such a job is offered, it must be at least 90 days in duration." **(At the time of your injury, (DOI), you were assigned in a temporary position.)**

The (AGENCY) offering the following position:

NAME: _____

DATE OF INJURY: _____

FILE NUMBER: _____

EMPLOYER: _____ and _____ADDRESS_____

a. Position Title: _____

b. Series/Grade/Salary: _____
Annual Salary including locality pay, _____ Hourly Rate$___

c. (Locality and address of Position) _____

d. Approximately _____ miles from home of Record

e. Agency is paying relocation expenses, if applicable

f. Duty Hours: 40 hours per week

g. Monday – Friday
7:30am – 4:30pm
***Adjusted Work Schedule**

h. Work Accommodations:

- **Example: Exactly in accordance with medical restrictions and limitations:**

***Work station and any necessary personal medical restrictions required will be met by agency.**

Intermittent breaks every ____minutes for __ minutes.
Lifting not to exceed ___ pounds
Standing ____ hours a day
No Climbing.

i. Start Date: _____Ending Date: If Temporary

j. Grade and salary on Date of Injury: Annual Salary $_____
hourly rate $ ____
•k. Current salary for grade and step of position held on Date of Injury:
Annual Salary $_____ hourly rate $_____.
2.A copy of the Official Position Description detailing specific duties and responsibilities is enclosed for your information. The duties assigned and defined in this job offer are individually and collectively within your medical restrictions, dated _____, by Dr. _____.
3. This position is to be performed within your medical restrictions.
4.Your decision whether to accept or decline this offer should be made in writing and received in our office not later than (Suspense Date: 3-5 Workdays). The enclosed Statement is provided for your decision. Failure to notify this office of your decision will constitute a rejection of a valid job offer. We will notify OWCP of your decision or failure to respond. OWCP will notify you of your rights.
5.We are providing OWCP with all documentations of this job offer.
6.Please contact _____regarding any questions or concerns you may have.
7.Sincerely,
Encl:
Acceptance/Declination Statement 2. or 3.
Position Description
Medical Restrictions
CF: OWCP
6.ACCEPTANCE/DECLINATION STATEMENT

•
•

PART A ACCEPTANCE

•

I _____voluntarily accept this position annual salary _____hourly rate $_____, including locality pay.

Effective Date:_____Ending Date: (If Temporary)
SIGNATURE

PART B DECLINATION

I _____decline this offer of placement to the position of

annul salary $_____ hourly rate $_____including locality

I fully understand the consequences that if I decline this job offer and OWCP determines this is a suitable job offer, my compensation may be terminated under the Federal Employees Compensation Act.

_____DATE:_____
SIGNATURE

APPENDIX F.

RECORDS MANAGEMENT

A. Employee

1. Responsibilities Checklist
2. Monitoring Bill Payment

B. Supervisor's

Checklist

C. Agency Injury Compensation Specialist

1. Department of Labor Memorandum: Timelines
2. Employee File Claim History Sheet
3. OWCP Claimant Notes
4. Claimant Claim Process Checklist
5. Sample Agency Homepage OWCP Internet News
6. Semi-Annual Reporting
7. Supervisor/Employee Training

EMPLOYEE RESPONSIBILITIES
WORKERS' COMPENSATION CHECKLIST

Name: _____ Date of Injury: _____

IMMEDIATELY NOTIFY SUPERVISOR OF INJURY.
Seek medical treatment – preferably on the date of injury. Choose treating physician. Obtain CA-16 (Only for Traumatic Injury **and** if CA-1 is filled within one week of injury) and CA-17.
Complete his/her portion of the CA-1 or CA-2 and appropriate CA-35, and submit to supervisor.
Obtain Receipt of Notice of Injury.
If injury has caused you to miss work, obtain and provide medical documentation to supervisor to justify all absences due to work-related injury/illness, and let your supervisor know when you expect to return to work.
If you expect to remain out of work for more than 45 calendar days, inform your supervisor and complete the employee section of the CA-7, CA-7A, & SF-1199A. Have your treating physician complete the CA-20.
Bring back to your supervisor an updated CA-17 (Duty Status Report) after **EVERY** medical appointment until returned to full duty.
Inform supervisor of the type of leave requested (e.g., Sick, Annual, LWOP or COP). You **MUST** follow the same established leave procedures as if you were not at work for other reasons.
If COP is requested, you **MUST** provide Medical Evidence supporting your need within **10 calendar** days of that request.
All COP used **MUST** subsequently be verified and supported by medical documentation.
Return to work as soon as medically possible. Light duty should always be available to accommodate medical restrictions.
Contact the SPD CPAC Injury Compensation Program Administrators, at any time during the process for assistance. **E-mail:** DLL-CESPK-HR-EDI@eis01.usace.army.mil

WEB SITES:

Workers' Compensation Claim Forms and Information:
http://www.dol.gov/esa/regs/compliance/owcp/forms.htm

SPD CPAC Online Information Center (Benefits):
http://www.spd.usace.army.mil/cpac/benefits.html

KEY TERMS:

CA-1 – Traumatic Injury – is a wound or other condition of the body caused by external force, including stress or strain, sustained during the course of one work day. Claim must be filled with in 30 days of injury to use COP.

CA-2 – Occupational Disease – is defined as a condition produced in the work environment over a period longer than one workday or shift.

CA-7 – Claim for Compensation of Account of Traumatic Injury or Occupational Disease.

CA-7A – Time Analysis Form.

CA-7B – Leave Buy-Back (LBB) Worksheet / Certification and Election.

CA- 16 – Authorizations for Examination and/or Treatment.

CA-17 – Duty Status Report.

CA-20 – Attending Physician's Report

CA-35 – Evidence Required in Support of a Claim for Occupational Disease.

COP – Continuation of Pay (only for Traumatic injuries if CA-1 filed within 30 days of injury).

ICPA – Injury Compensation Program Administrator.

LWOP – Leave Without Pay.

You and your Care Provider can monitor bills at this site:

https://owcp.dol.acs-inc.com/portal/main.do;PORTAL_JSESSIONID=DyHL9ncGw0DTvqC1S2NHNRwd7dhJJT6JynL180WxnZQ4MLTpYpn1!-997277189 Right click and select open hyperlink

Provider
Claimant
Agency

Use the FECA Icon to log in.

Claimants will need their claim number and Care Providers need to register to get a password.

1b.

ACS

Submit Medical Bills & Medical Documentation/Correspondence To:
U.S. Dept of Labor OWCP – Central Mailroom, P.O. Box 8300, London KY 40742-8300
Phone: (850) 558-1818 or (866) 335-8319 Toll Free IVR
ACS Authorization Fax # (800) 215-4901
ACS Website: http://owcp.dol.acs-inc.com

Prescription Benefit Inquiries: (866)-664-5581
ACS Help Desk For Providers: (800)461-7485

Provider Checklist:
Provider enrolled with ACS/ACS provider number on bill
FECA Case # on medical bill & documentation
Medical documentation submitted to the Department of Labor (DOL)
Prior authorization requested
Diagnosis code obtained from injured employee/copy of DOL letter

This card is provided for informational purposes only and is not a guarantee of payment (2 of 2) Updated12/07

Supervisor's OWCP Checklist	
1.	**Report Injury Immediately** – ***Must submit CA-1 to get OWCP Claim Number***
	• Electronically submit CA-1, Traumatic Injury or CA-2, Occupational Disease • Website: http://www.cpms.osd.mil/icuc/EDI.aspx (EDI - Supervisor Link) • For Recurrence Claims (spontaneous return) submit CA-2a manually to ICPA
2.	**Notify Safety** -
	• Air National Guard – Submit local safety forms to their Safety Office • Army National Guard – Submit DA Form 285-AB-R to State Safety Office
3.	**Medical Documentation – *Must be signed by physician***
	• CA-16, Authorization for Examination & Treatment **within 48 hours of injury** (issue only one CA-16 per injury) • CA-20, Attending Physician's Report (each time medical treatment received) • CA-17, Duty Status Report (Must submit after each treatment) – Send with Position Description • **Injured employee must notify physician that Agency offers light duty**
4.	**Continuation of Pay (COP) – *Must be supported by medical documentation***
	• 45 calendar days entitlement following date of traumatic injury • Time card code for COP: "LU" for date of injury & "LT" 45 days after injury • Four digit code for time card is month & day of injury • If claim is denied, change COP to LS, LA, or LWOP
5.	**Medical Authorization – *Must be supported by medical justification***
	• Physician requests authorization: phone (866)335-8319 or (850)558-1818 or fax (800)215-4901 or Website: http://owcp.dol.acs-inc.com • Medical Provider must have ACS Provider Number to receive authorization • Physician must state ICD-9, (diagnosis code) & CPT (procedure code), and OWCP Claim Number (Codes must match accepted condition)
6.	**Compensation after 45 days – *Must be supported by medical documentation***
	• Must be in Leave Without Pay (LWOP) Status • Time card code for LWOP: "KD" • CA-7, Claim for Compensation (Submit every two weeks) • SF1199A, Direct Deposit Sign-up • After 80 hours of LWOP, submit SF52 to HRO requesting LWOP status • Pay rate is three-fourths with dependents and two-thirds without dependents
7.	**Medical Bills** -
	• Web site: http://owcp.dol.acs-inc.com

	• Medical Provider must have ACS Provider Number to receive payment • Bills submitted manually –Medical Providers (excluding Pharmacy) must bill with their ACS OWCP provider number in box 33 of OWCP-1500 or box 51 of OWCP-04. If the number is not on the form medical bill will be returned • Mailing address: Dept of Labor, P.O. Box 8300, London, KY 40742-8300 • ACS Customer Service (850) 558-1818
8.	**Reimbursement –**
	• OWCP-915, Medical, submit with required documentation • OWCP-957, Travel, submit with required documentation • Send completed forms, with required documentation, to the Dept of Labor, P.O. Box 8300, London, KY 40742-8300,
9.	**Agency Point of Contact – Injury Compensation Program Administrator (ICPA)**
	Tammy Lashley, ICPA–DSN 256-6627, CML (508)233-6627, toll free 888-301-3103 x6627.MA National Guard JFHQ, HRO-OWCP, 50 Maple Street, Milford, MA 01757

1. **SUPERVISOR ACCOUNTABILITY:**

- ✓ **Create and Maintain Safe and Healthful Worksite**
- ✓ **Inspect work areas for hazards**
- ✓ **Correct them**
- ✓ **Prevention/Safety Education in Working Safely**
- ✓ **Conduct Safety Meetings**
- ✓ **Ensure Required Personal Protective Equipment (PPE)**
- ✓ **Comply with, and**
- ✓ **Enforce Safety Regulations**
- ✓ **Standing Operating Procedures (SOPs)**
- ✓ **Take action:**
- ✓ **Safety Standards, Rules and Regulations violated**
- ✓ **Document Safety Violations**
- ✓ **Facilitate accident reporting and investigations**
- ✓ **Hold employees accountable for safety!**

2. **WHEN AN INJURY OCCURS:**

- ✓ **Supervisor <u>MUST</u> Process all OWCP Claims**
- ✓ **IMMEDIATELY!**
- ✓ **Can not "NOT" file claim**
- ✓ **Traumatic Injury Only (CA1):**
- ✓ **Authorize Continuation of Pay (COP)**
- ✓ **Unless, Controverting (one of nine reasons)**
- ✓ **OWCP "adjudicates"**
- ✓ **Submit proper forms….TIMELY**

- ✓ **When Appropriate: @ "Submission of Claim"**
- ✓ **Controvert COP (Traumatic Injury (CA1): (One of Nine Reasons)**
- ✓ **Challenge Claim**
- ✓ **Issue CA16 Authorization for Examination and/or Treatment**

✓✓ **When Appropriate**

- ✓ **Within 4 hours of report**
- ✓ **When in doubt of circumstances**
- ✓ **Indicate on CA16**
- ✓ **Retroactive issuance is not permitted**
- ✓ **Keep CA16's protected**

- ✓ **Supervisor may still issue CA16 if:**
  Employee reported injury Did not request medical treatment with in 24 hours
- ✓ **If more than week - No Use discretion**
- ✓ **Issue ACS Card: Billing information & Medical Authorizations**
- ✓ **Light Duty – Accommodations**

Post on Employees' Bulletin Board

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
U.S. GOVERNMENT PRINTING OFFICE: 1991 0-866-435 Form CA-10
Rev. Aug. 1987

What A Federal Employee Should Do When Injured At Work

Report to Every job-related injury should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices.

Supervisor

Obtain Before you obtain medical treatment, ask your supervisor to authorize medical treatment by use of form CA-16. You may initially select the physician to provide necessary treatment. This may be a private physician or, if available, a local Federal medical officer/hospital. Emergency medical treatment may be obtained without prior authorization. Take the form CA-16 and form OWCP-1500/HCFA-1500 to the provider you select. The form OWCP-1500/HCFA 1500 is the billing form physicians must use to submit bills to OWCP. Hospitals and pharmacies may use their own billing forms. On occupational disease claims form CA-16 may not be issued without prior approval from OWCP.

Medical Care

File In traumatic injuries, complete the employee's portion of Form CA-1. Obtain the form from your employing agency, complete and turn it in to your supervisor as

Written Notice soon as possible, but not later than 30 days following the injury. For occupational
disease, use form CA-2 instead of form CA-1. For more detailed information carefully read the "Benefits ..." and "Instructions ..." sheets which are attached to the Forms CA-1 and CA-2.

Obtain A "Receipt" of Notice of Injury is attached to each Form CA-1 and Form CA-2. Your supervisor should complete the receipt and return it to you for your personal

Receipt of Notice records. If it is not returned to you, ask your supervisor for it.

Submit Claim For If disabled due to traumatic injury, you may claim continuation of pay (COP) not to
exceed 45 calendar days or use leave. A claim for COP must be submitted no later than 30 days following the injury (the form CA-1 is designed to serve as a claim for continuation of pay). If disabled and claiming COP, submit to your employing agency within 10 work days medical evidence that you sustained a disabling traumatic injury. If disabled beyond the COP period, or if you are not entitled to COP, you may claim compensation on form CA-7 or use leave. If disabled due to occupational disease, you may claim compensation on form CA-7 or use leave. A claim for compensation for disability should be submitted as soon as possible after it is apparent that you are disabled and will enter a leave-without-pay status.

COP/Leave and/or
Compensation
For Wage Loss

The Federal Employees' Compensation Act (FECA) is administered by the U.S. Department of Labor, Employment
Standards Administration, Office of Workers' Compensation Programs (OWCP). Benefits include continuation of

pay for traumatic injuries, compensation for wage loss, medical care and other assistance for job-related injury or
death. For additional information about the FECA, read pamphlet CA-11, "When Injured at Work" or Federal
Personnel Manual, Chapter 810, Injury Compensation, available from your employing agency. The agency will also
give you the address of the OWCP Office which services your area.

Employment Standards Administration

U.S. DOL Office of Workers' Compensation Programs
Division of Federal Employees' Compensation

TIMELINESS

Federal agencies are required by regulation to submit an employee's Notice of Injury (Form CA-1 or CA-2) within 10 working days (or 14 calendar days) of receiving it from an employee, if lost time from work or medical expenses are claimed or anticipated (20 CFR 10.110(a)). Regulations require that the CA-7 should be submitted no later than 5 working days (or 7 calendar days) after its receipt from the employee (20 CFR 10.112(b)). This prompt submission is critical if OWCP is to be able to serve injured workers' needs and especially to ensure that medical bills can be processed timely.

Some injuries will be promptly reported to the agency but held there because no lost time or medical expenses are claimed. Thus, OWCP does not expect every CA-1 or CA-2 to be submitted within the timeframe. However, the great variation among agencies suggests that internal agency practices in handling notices of injury are a large contributor to delay and can be improved.

Statistics prove that injured employees will return to work more quickly when their claims are processed in an expeditious manner. This return-to-work effort begins by timely submitting forms to OWCP.

EMPLOYEE FILE CLAIM HISTORY SHEET

CLAIMANT NAME: _____ **OWCP CASE #**: _____

CONTACT INFORMATION:

Claimant phones: _____ Spouse name: _____

Physician Name: _____ Phone/Fax: _____ Contact _____

Physician Name: _____ Phone/Fax: _____ Contact _____

Claims Examiner Name: _____ Phone: _____

EVENTS:

Date	Contact	Description of events	Resolution

OWCP CLAIM STATUS CODES

CODE	EXPLANATION
C1	**Closed, No Time Lost**
C2	**Closed; Leave**
C3	**Closed, Denial of Benefits**
C4	**Closed; Continuation of Pay (COP)**
C5	**Closed; Other Benefits Due Have Been Paid**
DE	**Death; Benefits to Dependents**
DR	**Daily roll; COP; Return to Work (RTW)**
MC	**Medical Care Only**
ON	**Overpayment/No Compensation**
OP	**Overpayment/Permanent Roll**
PN	**Permanent Roll, Not Rate able, *Medical Due every 3 years***
PR	**Permanent Roll, (Periodic) *Medical Due Every Year***
PS	**Scheduled Award**
PV	**Permanent; Rehabilitation**
PW	**Permanent; Loss Wage Earnings (LWEC) *Example:* RTW**
UD	**Case, Under Development**

5.

SAMPLE LETTERS

6.

AGENCY NEWSLETTERS

DISCLOSURES FOR WORKERS' COMPENSATION PURPOSES

[*45 CFR 164.512(l)*]

Background

The HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers' compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by State or other law. Due to the significant variability among such laws, the Privacy Rule permits disclosures of health information for workers' compensation purposes in a number of different ways.

How the Rule Works

Disclosures Without Individual Authorization. The Privacy Rule permits covered entities to disclose protected health information to workers' compensation insurers, State administrators, employers, and other persons or entities involved in workers' compensation systems, without the individual's authorization: C As authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. This includes programs established by the Black Lung Benefits Act, the Federal Employees' Compensation Act, the Longshore and Harbor Workers' Compensation Act, and the Energy Employees' Occupational Illness Compensation Program Act. See 45 CFR 164.512(*l*).C To the extent the disclosure is required by State or other law. The disclosure must comply with and be limited to what the law requires. See 45 CFR 164.512(a). C For purposes of obtaining payment for any health care provided to the injured or ill worker. See 45 CFR 164.502(a)(1)(ii) and the definition of "payment" at 45 CFR 164.501. Disclosures With Individual Authorization. In addition, covered entities may disclose

protected health information to workers' compensation insurers and others involved in workers' compensation systems where the individual has provided his or her authorization for the release of the information to the entity. The authorization must contain the elements and otherwise meet the requirements specified at 45 CFR 164.508. Minimum Necessary. Covered entities are required reasonably to limit the amount of protected health information disclosed under 45 CFR 164.512(l) to the minimum necessary to accomplish the workers' compensation purpose. Under this requirement, protected health information may be shared for such purposes to the full extent authorized by State or other law. In addition, covered entities are required reasonably to

limit the amount of protected health information disclosed for payment purposes to the minimum necessary. Covered entities are permitted to disclose the amount and types of protected health information that are necessary to obtain payment for health care provided to an injured or ill worker. Where a covered entity routinely makes disclosures for workers' compensation purposes under 45 CFR 164.512(*l*) or for payment purposes, the covered entity may develop standard protocols as part of its minimum necessary policies and procedures that address the type and amount of protected health information to be disclosed for such purposes. Where protected health information is requested by a State workers' compensation or other public official, covered entities are permitted to reasonably rely on the official's representations that the information requested is the minimum necessary for the intended purpose. See 45 CFR 164.514(d)(3)(iii)(A). Covered entities are not required to make a minimum necessary determination when disclosing protected health information as required by State or other law, or pursuant to the individual's authorization. See 45 CFR 164.502(b). The Department will actively monitor the effects of the Privacy Rule, and in particular, the minimum necessary standard, on the workers' compensation systems and consider proposing modifications, where appropriate, to ensure that the Rule does not have any unintended negative effects that disturb these systems. Refer to the fact sheet and frequently asked questions on this web site about the minimum necessary standard, or to 45 CFR 164.502(b) and 164.514(d), for more information.

Frequently Asked Questions

OCR HIPAA Privacy

December 3, 2002

Revised April 3, 2003

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To see Privacy Rule FAQs, click the desired link below:

FAQs on Workers' Compensation Disclosures

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)