Office of Worker’s Compensation (OWCP)

Supervisor Training

Catrecia J. Lewis, HR Specialist/ICPA
Hawaii National Guard
Traumatic Injury - Definition

- Wound or other condition of the body caused by external force, including stress or strain.

- Caused by a specific event or series of events or incidents within a single work day or work shift.
DO NOT HOLD!

- Filed electronically by supervisor.

- Must be submitted to employing agency within 30 days of date of injury to be eligible for COP – however can be submitted up to three years after the injury.

- Must be transmitted to OWCP within 10 work days from the date the agency received it.
Federal Employee’s Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

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**

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of employee (Last, First, Middle)</td>
</tr>
<tr>
<td>2</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>3</td>
<td>Date of birth Mo. Day Yr.</td>
</tr>
<tr>
<td>4</td>
<td>Sex [ ] Male [ ] Female</td>
</tr>
<tr>
<td>5</td>
<td>Home telephone</td>
</tr>
<tr>
<td>6</td>
<td>Grade as of date of injury Level Step</td>
</tr>
<tr>
<td>7</td>
<td>Employee’s home mailing address (Include city, state, and ZIP code)</td>
</tr>
<tr>
<td>8</td>
<td>Dependents [ ] Wife, Husband [ ] Children under 18 years [ ] Other</td>
</tr>
</tbody>
</table>

**Description of Injury**

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th &amp; Pine)</td>
</tr>
<tr>
<td>10</td>
<td>Date injury occurred Mo. Day Yr. Time [ ] a.m. [ ] p.m.</td>
</tr>
<tr>
<td>11</td>
<td>Date of this notice Mo. Day Yr.</td>
</tr>
<tr>
<td>12</td>
<td>Employee’s occupation</td>
</tr>
</tbody>
</table>

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)

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 thereby 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 5954. |

   b. Sick and/or Annual Leave

16. I hereby authorize any physician or hospital (or any other person, institution, corporation, or governmental 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**

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

**Form CA-1**

Rev. Apr. 1999
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):

---

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

---

20. Regular work hours:
   - From: [ ] a.m. [ ] p.m. To: [ ] a.m. [ ] p.m.
   - CSRS \[ ] FERS \[ ] Other, (identify)

---

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 work stopped:
   - Mo: [ ] Day: [ ] Yr: [ ]

---

25. Date pay stopped:
   - Mo: [ ] Day: [ ] Yr: [ ]

---

26. Date 45 day period began:
   - Mo: [ ] Day: [ ] Yr: [ ]

---

27. Date returned to work:
   - Mo: [ ] Day: [ ] Yr: [ ]

---

29. 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 continues to withhold the reason in detail.

---

37. Pay rate when employee stopped work:
   - Par

---

**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-60-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.
   - [ ] Other:

---

Form CA-1, Rev Apr. 1999
Occupational Disease

- Condition attributable to exposure to work factors over a period longer than one work day or shift.

- Continuation Of Pay (COP) is not provided.

- CA-16 is not issued.
Must be submitted to employing agency within 3 years of the date when the employee becomes aware, or reasonably should have been aware, of a possible relationship between the medical condition and the employment, or the date of last exposure.

Must be transmitted to OWCP within 10 work days from the date the agency received it.
Notice of Occupational Disease and Claim for Compensation

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.

<table>
<thead>
<tr>
<th>Employees Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of employee (Last, First, Middle)</td>
<td>2. Social Security Number</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Date of birth</td>
<td>4. Sex</td>
</tr>
<tr>
<td>NO. Day Yr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Home telephone</td>
<td>6. Grade as of date of last exposure Level Step</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Employee's home mailing address (Include city, state, and ZIP code)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Employee's occupation</td>
<td>9. Occupation code</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Location (address) where you worked when disease or illness occurred (Include city, State, and ZIP code)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Date you first became aware of disease or illness</td>
<td></td>
</tr>
<tr>
<td>NO. Day Yr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 12. Date you first realized the disease or illness was caused or aggravated by your employment | 13. Explain the relationship to your employment, and why you came to this realization |
| NO. Day Yr              |                      |
|                         |                      |

14. Nature of disease or illness

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

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

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

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature of employee or person acting on his/her behalf</td>
<td>Date</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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

Form CA-2
Official Supervisor's Report of Occupational Disease: Please complete information requested below

<table>
<thead>
<tr>
<th>Supervisor's Report</th>
<th>OWCP Agency Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.</td>
<td>Employee's duty station (Street address and ZIP Code)</td>
</tr>
<tr>
<td></td>
<td>ZIP Code</td>
</tr>
<tr>
<td>21. Regular work hours</td>
<td>☐ a.m.</td>
</tr>
<tr>
<td>23. Name and address of physician first providing medical care (include city, state, ZIP code)</td>
<td></td>
</tr>
<tr>
<td>24. First date medical care received</td>
<td></td>
</tr>
<tr>
<td>25. Do medical reports show employee is disabled for work?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>26.</td>
<td>Date employee first reported condition to supervisor</td>
</tr>
<tr>
<td></td>
<td>Mo. Day Yr.</td>
</tr>
<tr>
<td>27. Date and hour employee stopped work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mo. Day Yr.</td>
</tr>
<tr>
<td>28. Date and hour employee's pay stopped</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mo. Day Yr.</td>
</tr>
<tr>
<td>29. Date employee was last exposed to conditions alleged to have caused disease or illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mo. Day Yr.</td>
</tr>
<tr>
<td>30. Date returned to work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mo. Day Yr.</td>
</tr>
<tr>
<td>31. If employee has returned to work and work assignment has changed, describe new duties</td>
<td></td>
</tr>
<tr>
<td>32. Employee's Retirement Coverage</td>
<td>☐ CSRS</td>
</tr>
<tr>
<td>33. Was injury caused by third party?</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>34. Name and address of third party (include city, state, and ZIP code)</td>
<td></td>
</tr>
<tr>
<td>35. Signature of Supervisor</td>
<td></td>
</tr>
</tbody>
</table>

Signature of Supervisor

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

Form CA-2

Checklist

- CA-35a – Occupational Disease in General
- CA-35b – Hearing Loss
- CA-35c – Asbestos-Related Illness
- CA-35d – Coronary / Vascular Condition
- CA-35e – Skin Disease
- CA-35f – Pulmonary Illness (Not Asbestosis)
- CA-35g – Psychiatric Illness
- CA-35h – Carpal Tunnel Syndrome
Medical - Treatment

- **Emergency**
  - When an employee sustains a work-related traumatic injury that requires medical examination, medical treatment or both, the employer shall authorize such examination and/or treatment by issuing a Form CA-16.

- **Choice of Physician**
  - The employee has the right to choose their own physician.
Medical – CA-16

- Controlled form, must call agency ICPA or Regional Liaison for form.
- Issue within 4 hours of the claimed injury.
- **NOT** issued for Occupational Disease claims (CA-2)
Authorization for Examination
And/Or Treatment

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

The following request for information is required under 29 U.S.C. 8101 et seq. Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless the report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-106. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

PART A - AUTHORIZATION

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

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

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

4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item 4, and to the condition indicated either 1 or 2, in item 5.

A. Your signature in item 5 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

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

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

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

8. Signature of Authorizing Official:

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

10. Local Employing Agency Telephone Number:

11. Date (mo., day, year)

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

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

Department of Agency
Bureau or Office
Local Address (including ZIP Code)

Public Burden Statement
We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3228, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16

CA-16
Conditions of Coverage

- Time
- Civilian Employee
- Fact of Injury
- Performance of Duty
- Causal Relationship
Conditions of Coverage
Statutory Exclusions

- Drug or Alcohol intoxication – proximately caused the injury.
- Intent to injure self or others – intent must be established.
Time

- Employee has three years from:
  - Date of Injury
  - Date of First Awareness
  - Date of Last Exposure
Civilian Employee

- FECA covers all civilian employees except for non-appropriated fund employees.
- Temporary employees covered on the same basis as permanent employees.
- Contract employees, volunteers, and loaned employees are covered under some circumstances.
Fact of Injury

- Factual – Actual occurrence of an accident, incident, or exposure in time, place, and manner alleged.

- Medical – A medical condition diagnosed in connection with that accident, incident or exposure.
Performance of Duty

- Injury occurred while performing assigned civilian technician duties or engaging in an activity reasonably associated with the employment.

- Injury occurred on work premises.
  - Use of facilities for personal comfort.
  - Includes parking facilities owned by employer.
  - Coverage extended for a reasonable time before or after work hours.
Performance of Duty

- Injury occurred off premises while engaging in work activities.
  - Employees are not covered en route between work and home unless the agency furnishes transportation, the employee is required to travel during a curfew or emergency or the employee is required to use their personal vehicle during the work day.
Performance of Duty (continued)

- Other factors
  - Recreation
  - Horseplay
  - Assault
  - Harassment or Teasing
  - Idiopathic Falls
  - Emergencies
  - Union Representation
Causal Relationship

- Link between work-related exposure/injury and any medical condition found.
- Based entirely on medical evidence provided by physicians who have examined and treated the employee.
- Opinions of employee, supervisor, or witnesses not considered – nor is general medical information contained in published articles.
Causal Relationship (continued)

- Direct Causation – injury or factors of employment result in condition claimed through natural and unbroken sequence.
- Aggravation – preexisting condition worsened, either temporarily or permanently, by a work-related injury.
- Acceleration – a work-related injury or disease may hasten the development of an underlying condition.
- Precipitation – a latent condition that would not have manifested itself on this occasion but for the employment.
Recurrence

- A spontaneous return of symptoms or increase of disability due to a previous injury or occupational disease without intervening cause, or a return or increase of disability due to a consequential injury.
- A recurrence of a medical condition is defined as a documented need for further medical treatment for the accepted condition or injury when there is no accompanying work stoppage.
- Wage loss resulting from the withdraw of light duty accommodation.
- No event other than the previous injury accounts for the disability.
### Notice of Recurrence

**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.

#### 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**<br>Mo. Day Yr.
5. **Sex**<br>☑ 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)
   - At time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.

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

   - Medical Treatment Only
   - Time Loss From Work

15. **Date of first medical treatment following recurrence (mo., day, year)**

16. **Name and address of treating physician**

17. **After returning to work following the original injury, were you in any way limited in performing your usual duties?**<br>☐ Yes ☐ No

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

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

20. **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 a 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 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.

21. **Signature of employee**
22. **Date (mo., day, year)**
Part B - Federal Employing Agency

26. Name and address of reporting office (include city, state, and ZIP Code)

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

28. Regular work hours

29. Regular work days

30. Date of injury

31. Date of recurrence

32. Date stopped work after recurrence

33. Date stopped after recurrence

34. Dates COP paid for recurrence

35. Date returned to work after recurrence

36. Did the employee receive medical care at an agency facility due to the recurrence? (Yes) (No)

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-167? (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)

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? (Yes) (No)

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

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)

42. Title

43. Work phone

44. Date (mo., day, year)
Continuation of Pay

- Definition
- Eligibility
- Calculation
- Controversion
Continuation of Pay - Definition

- The continuation of the employee’s regular pay for a period not to exceed 45 calendar days of disability.

- COP is not considered compensation and therefore is subject to income taxes, retirement and other usual payroll deductions.
Continuation of Pay - Eligibility

- Must file for a traumatic injury, within 30 days of the date of injury.
- Must begin losing time from work within 45 days of the injury.
- May resume using unused COP within 45 days after the first return to work.
Continuation of Pay - Calculation

- The pay rate for COP purposes is equal to the employee’s regular weekly pay rate. Excludes overtime pay, but includes other applicable extra pay except to the extent prohibited by law.

- Changes in pay which would have otherwise occurred during the 45 day period are to be reflected. (i.e., promotion, demotion, step increases)
COP
Controversion

- The disability was not caused by a traumatic injury;
- The employee is not a citizen of the United States or Canada;
- No written claim was filed within 30 days from the date of injury;
- The injury was not reported until after employment had been terminated;
- The injury was not sustained while in the performance of duty;
- The injury was caused by the employee’s willful misconduct, intent to injure or kill him/herself or another person, or was proximately caused by intoxication by alcohol or illegal drugs; or
- Work did not stop until more than 45 days following the injury.
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. 1215-0193
   Expires: 08/31/2005
   c. OWCP File Number

b. Mailing Address (Including City, State, ZIP Code)

c. Social Security Number

E-Mail Address (Optional)

T. 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 with pay
   Yes
   No
   Go to Section 3, and Complete Form CA-7b

c. Other wage loss, specify type:
   such as down grade, loss of
   night differential, etc.
   Intermittent?
   Yes
   No
   Go to Section 3

   If intermittent, complete Form CA-7a.
   Type:
   Schedule Award (Go to Section 4)
   Time Analysis Sheet

SECTION 3
Have you worked outside of your federal job during the period(s) claimed in Section 2?

Yes
Name and Address of Business

No
Go to Section 4

Date Worked
Type of Work

SECTION 4
Is this the first CA-7 claim for compensation you have filled 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 changes

No - Complete Section 7

SECTION 5
List your dependents (including spouse)

Name
Social Security 

Date of Birth
Relationship

 Lv ing 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
   Claim Number
   Full Address of VA Office Where Claim Filed
   Nature of Disability and Monthly Payment
   No
  ...

c. Have you applied for or received payment under any Federal Retirement or Disability
   law?
   Yes
   Claim Number
   Date Annuity Began
   Amount of Monthly Payment
   Retirement System (CSRS, FERS, SSA, Other)
   No
   ...

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

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of
fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that
person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may,
der 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)

Form CA-7
Rev. Nov. 1999
**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

<table>
<thead>
<tr>
<th>Date of Injury</th>
<th>Show Pay Rate as of</th>
<th>Additional Pay Type</th>
<th>Additional Pay Type</th>
<th>Additional Pay Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Base Pay per</td>
<td>$</td>
<td>per</td>
<td>$</td>
</tr>
<tr>
<td>Grade:</td>
<td>Step:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date Employee Stopped Work:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Base Pay per</th>
<th>Additional Pay Type</th>
<th>Additional Pay Type</th>
<th>Additional Pay Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade:</td>
<td>Step:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP). Substantiation of such payments must be provided on Form CA-7a, Time Analysis Sheet.

### SECTION 9

(SUE), Quarter (QTR), etc. (List each separately)

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

<table>
<thead>
<tr>
<th>WEEK 1 From 5/14 to 5/20</th>
<th>WEEK 1 From 5/6 to 5/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7</td>
<td>0 1 2 3 4 5 6 7</td>
</tr>
<tr>
<td>S M T W TH F S</td>
<td>S M T W TH F S</td>
</tr>
</tbody>
</table>

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 entitled to:

a. Health Benefits under the FEHBP? Yes [] No []
   Code: ____________________

b. Basic Life Insurance? Yes [] No []

c. Optional Use Insurance? Yes [] No []
   Code: ____________________

d. A Retirement System? Yes [] No []
   Plan: ____________________
   (Specify CSRS, FERS, Other)

### SECTION 11

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

From __________ To __________ Intermittent? Yes [] No []

Yes — Complete Time Analysis Sheet, Form CA-7a

### SECTION 12

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

- Sick Leave From __________ To __________ Intermittent? Yes [] No []
- Annual Leave From __________ To __________ Intermittent? Yes [] No []
- Leave without Pay From __________ To __________ Intermittent? Yes [] No []
- Work From __________ To __________ Intermittent? Yes [] No []

### SECTION 13

Did employee return to work? Yes [] No []

If Yes, date ____________

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties? Yes [] No []

If No, explain:

### SECTION 14

Remarks:

### SECTION 15

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

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

Signature ______________________ Title ______________________ Date __________

Name of Agency ______________________

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

Name ______________________ Title ______________________

Telephone No. ______________________ Fax No. ______________________ E-Mail Address ______________________
Time Analysis Form

1. Name of Employee: (Last, First, Middle)  
2. SSN  
3. OWCP File Number

4. Period Covered by This Form:  
   From: _____ / _____ / ______  
   To: _____ / _____ / ______

5. Total Hours Claimed  
   for LWOP: ___________  
   for Leave BuyBack: ___________

6. In “Type of Leave Used” column, use codes “S” Sick, “A” Annual, “O” Other. If compensation is claimed for date, indicate “Yes” in “Compensation Claimed” column.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Compensation Claimed?</th>
<th>Number of Hours Worked</th>
<th>Type of Leave Used</th>
<th>Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Totals

Signature of Claimant

Date Signed

7. Agency Statement/Certification: I certify the above is accurate, except as follows:

Signature of Agency Official

Date Signed
Leave Buy Back (LBB) Worksheet/ Certification and Election

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

A. Name of Employee: (Last, First, Middle)

B. OWCP File Number:

C. Social Security Number:

D. Period for Which Compensation is Claimed to Repurchase Leave
   From: ______ / ______ / ______
   To: ______ / ______ / ______

I. Agency Estimate of FECA Entitlement:
   A. Weekly Base Payrate (excluding overtime)
      • Date of Injury: ______ / ______ / ______ $ __________
      • Date Stopped Work: ______ / ______ / ______ $ __________
      • Date of Recurrence: ______ / ______ / ______ $ __________

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

         ______ / ______
         ________________________________
         (effective date)

   B. Additions to Base Pay:
      If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 - by 52.
      • Night Differential
      • Sunday Premium
      • Subsistence/Quarters
      • Other (Specify)

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

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

   E. Total Hours Claimed on CA-7a

   F. Total Hours Worked per Week

   G. Formula (for FECA Entitlement)

   $ \left( \frac{\text{Weekly Payrate}}{\text{See Line 6}} \right) \times \left( \frac{\text{Compensation Rate}}{\text{See Line 7}} \right) \times \left( \frac{\text{Hours Worked/Wk}}{\text{See Line 8}} \right) = 10. \$
Return to Work

- CA-17
- Light Duty Offers
- Nurse Intervention
**Duty Status Report**

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 (USC 1101 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.

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

1. Employee's Name (Last, First, Middle)
2. Date of Injury (Month, day, yr.)
4. Occupation
5. Describe How the Injury Occurred and State Parts of the Body Affected

**SIDE B - Physician:** Complete this side.

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 7? □ 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 □ Part-Time or □ Full-Time Hrs Per Day □ No, if not, complete below:

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

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

**Form CA-17**
Return to Work
Injured Workers’ Responsibilities

- To seek or accept suitable employment.
- To resume Federal employment if capable.
- To provide physician with information on any available light duty.
Return to Work
Employer’s Responsibilities

- Authorize medical care.
- If alternative positions are available for partially disabled employees, advise the employee in writing of specific duties and physical demands.
- Where no alternative positions are available, advise the employee of any accommodations the agency can make.
Return to Work
Nurse Intervention

- Registered Nurses (RNs) under contract to OWCP
  - Meet with employees, physicians and agency representatives to ensure that proper medical care is being provided and to assist employees in returning to work.
  - Address questions and concerns about medical care, treatment plans, return-to-work dates, description of work limitations and explore availability of light or limited duty work.
Return to Work
Nurse Intervention (continued)

- The RN may occasionally coordinate care with an agency nurse. As a rule, however, agencies should not assign their own nurses to work with employees simultaneously with OWCP RNs.

- Should an employee refuse to cooperate with an OWCP nurse or refuse to make a good faith effort to obtain reemployment, OWCP may reduce or terminate compensation depending on the circumstances of the refusal.
THE END

Questions?