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.

CA-1

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.

CA-1

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

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

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth Mo. Day Yr.
4. Sex ☐ 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)

a. Occupation code

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

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

Form CA-1
Rev. Apr. 1999

CA-1

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

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.

CA-2,
Notice of Occupational Disease and Claim for Compensation

DO NOT HOLD!

- 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.

CA-2

Notice of Occupational Disease and Claim for Compensation

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

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

Employee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth Mo. Day Yr.
4. Sex
5. Home telephone ( )
6. Grade as of date of last exposure Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
6. Dependents
☐ 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 1 of the attached instructions is not submitted with this form, explain reason for delay.
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

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

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

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

Have your supervisor complete the receipt attached to this form and return it lo 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

CA-2

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 dat medical** care received 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

Form CA-2
Rev. Jan. 1997

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)

CA-16

Authorization for Examination And/Or Treatment

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

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

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: 10-31-99

PART A - AUTHORIZATION

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

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

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

4. Occupation

5. Description of Injury or Disease:

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

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

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

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

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

8. Signature of Authorizing Official:

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

10. Local Employing Agency Telephone Number:

11. Date (mo., day, year)

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

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

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

Department of Agency

Bureau or Office

Local Address (including ZIP Code)

Public Burden Statement

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16
Rev. Jan. 1997

Conditions of Coverage

- Time
- Civilian Employee
- Fact of Injury
- Performance of Duty
- Causal Relationship

Conditions of Coverage
Statutory Exclusions

- Willful Misconduct – deliberate and intentional disobedience of rules / orders. Not carelessness.
- 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.

CA-2a

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)

Form CA-2a
Rev. Sept. 1996

CA-2a

Part B - Federal Employing Agency

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

ZIP Code

OWCP Agency 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 Mo. Day Yr. From 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)

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.

CA-7

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:

☐ No *Go to on 4*

Name Address City State ZIP Code

Dates Worked: Type of Work:

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?

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

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

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

Form CA-7
Rev. Nov. 1999

CA-7

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 Type ___ | Additional Pay Type ___ | Additional Pay Type ___

Date: ___ $ ___ per ___ | $ ___ per ___ | $ ___ per ___ | $ ___ per ___

Grade: ___ Step: ___

Date Employee Stopped Work: | Type ___ | Type ___ | Type ___

Date: ___ $ ___ per ___ | $ ___ per ___ | $ ___ per ___ | $ ___ per ___

Grade: ___ Step: ___

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

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

SECTION 9

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

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S
2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	6		
WEEK 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 ___ *(Agency Official)* 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 ___

CA-7a

Time Analysis Form

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

Employee Statement - Please carefully read instructions on reverse *before* filling out this 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.

Date(s)	Compensation Claimed?	Number of Hours				Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Hol	Leave		
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 ____________

Form CA 7a
June 1996

CA-7b

Leave Buy Back (LBB) Worksheet/
Certification and Election

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

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

A. Name of Employee: *(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. 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 2. ______________
- Sunday Premium 3. ______________
- Subsistence/Quarters 4. ______________
- Other *(Specify)* 5. ______________

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

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

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

F. Total Hours Worked per Week 9. ______________

G. Formula *(for FECA Entitlement)*

$ ________ (Weekly Payrate See Line 6) x ________ (Compensation Rate See Line 7) x ________ (Hours See Line 8) ÷ ________ (Hours Wkd/Wk See Line 9) = 10. $ ______________

Return to Work

- CA-17
- Light Duty Offers
- Nurse Intervention

CA-17

Duty Status Report

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

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

OMB No. 1215-0103
Expires: 08-31-02

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	Intermittent		Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day	#lbs.	#lbs.	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

Form CA-17
Rev. Jan. 1997

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?