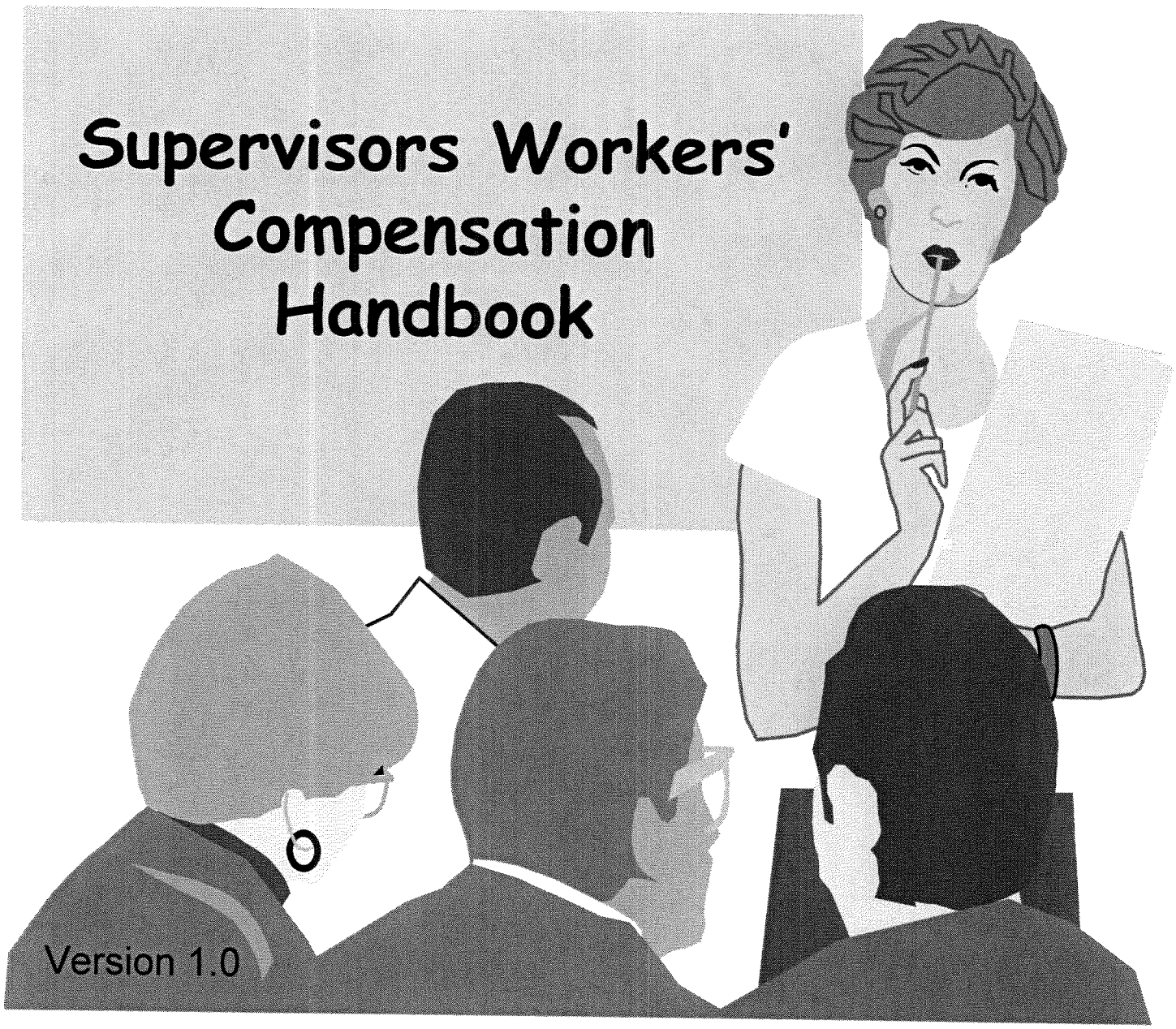
U.S. Department of Commerce



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Department of Commerce

Supervisors Workers' Compensation Handbook

Introduction

This handbook is designed for Supervisors. It is our goal that supervisors will have this handbook ready when an employee is injured or ill and will have the tools necessary to assist the employee in filing for compensation and returning the employee back to work after they are properly healed.

Civilian federal workers are covered under the Federal Employees' Compensation Act (FECA), which provides benefits for Federal workers' who are injured on the job, or who have sustained a work-related illness.

Although the Department of Labor administers the FECA program, all Department of Commerce (DOC) claims and claims-related material should be sent to the DOC centralized processing office.

Effective October 1, 2002, the workers' compensation processing and liaison services are being provided by a private vendor, Contract Claims Services, Incorporated (CCSI, L.P.). This contractor has extensive experience processing Federal government workers' compensation claims, and has a reputation for providing excellent customer service. CCSI will work closely with the Department of Labor to ensure all claims are processed timely.

All claims and claims-related information should be forwarded to CCSI, as follows:
In order to ensure timely claims submission, please have your supervisor send all initial claims (CA-1's and CA-2's) and claims for disability compensation (CA-7's) by Federal Express to the following address:

CCSI, L.P.
300 E. Royal Lane
Suite 200
Irving, TX 75039

All other claims-related documents should be sent to this address:

CCSI, L.P.
P.O. Box 542528
Dallas, TX 75354-2528
The contact numbers at CCSI, L.P. are (800) 743-2231,
FAX (888) 467-1273.

If you have any questions or concerns, or if you have suggestions which may help us to serve you better, you may contact Kathy Mattingly, Office of Occupational Safety & Health, at (202) 482-0689 or via e-mail at kmattingly@doc.gov or Adrienne Ross, Office of Occupational Safety & Health at (202) 482-4943 or via e-mail at aross@doc.gov.

Section 1

General Workers' Compensation Information

Workers' Compensation Guide for Supervisors

WHEN AN EMPLOYEE IS INJURED, YOU SHOULD:

- *Immediately offer medical treatment through the Health Unit or the employee's treating physician.*

- *When the employee is medically able, inform him/her that they may file for workers' compensation benefits by completing a CA-1 form, or **if they are not able**, you may complete the form on the employee's behalf.*

- *If a Health Unit is not available, you may issue a CA-16, Authorization for Examination and Treatment, to the employee, to provide for the payment of medical treatment by completing the front of the form.*
  - *Give this form to the employee within four hours, whenever possible.*
  - *You may issue the form even if you have doubts about the claim - you may indicate this in item 6(b).*
  - *A CA-16 form should not be issued more than 7 days after the date of injury, instead you should instruct the employee to contact CCSI for instructions.*
  - ***DO NOT ISSUE A FORM CA-16** if the claim is for an occupational illness.*
  - ***If you have any questions regarding Form CA-16, please contact CCSI.***

- *Review employee's section of the CA-1 for completeness and assist employee in completing any deficiencies. Complete and sign supervisor's section of the CA-1. **Box #23 "Date Notice Received" is the date that you receive the signed CA-1 from the employee.** NOTE: Make sure there is an election in item #15 and that there are original signatures in both items #15 and #37. Witness statements are not mandatory.*

- ***Completed forms should be sent to CCSI within 2 days after you receive them from your employee. Do not hold the CA-1 form for supporting documentation, etc.***

CONTINUATION OF PAY (COP)

*A supervisor may authorize COP for **up to ten (10) work days**, while waiting for medical evidence to support disability. Contact CCSI to let them know if COP has been authorized by the supervisor. CCSI may authorize COP for up to 45 calendar days, provided there is supporting medical evidence.*

The supervisor will be notified by CCSI regarding the acceptance/denial of the claim, and entitlement to COP.

PROVIDE THE FOLLOWING SUPPLEMENTAL INFORMATION, IF APPLICABLE:

* *Travel Orders*
* *Police reports (motor vehicle accidents)*
* *Diagram of the accident site (if the location of the injury occurs outside of a government building but in close proximity)*
* *Supplemental statements from the supervisor are required when the claims involves:*
    * *Recreational activities*
    * *Misconduct*
    * *Off-premise injuries*
    * *Altercations*

IF YOU REQUIRE ANY ASSISTANCE IN OBTAINING OR COMPLETING FORMS, OR IF YOU HAVE ANY QUESTIONS, YOU MAY CONTACT CCSI BY:

* ***CALLING :*** *1-800-743-2231*
* ***FAX:*** *1-888-467-1273*
* ***E-MAIL:*** *YEAKLE01@ccsholdings.com*
  RICHAS01@ccsholdings.com

Where to submit forms and documentation:

Overnight:

CCSI. L.P.
300 E. Royal Lane
Irving, TX 75039

Regular Mail:

CCSI, L.P
P.O. Box 542528
Dallas, TX 75354-2528

PERIODIC ROLL CLAIMS

* If it appears that a disability will continue for at least 60 days, the Department of Labor, Office of Workers' Compensation Programs, (OWCP), places the employee on the periodic roll and advises him or her on the amount of the payment that will be made every 28 days.

* OWCP also advises the employee that compensation will continue only through the date specified by OWCP's medical matrix or other procedural guidance, or by the attending physician's report; that he or she is expected to return to duty as soon as possible; and that he or she is expected to contact their agency to see if light duty or limited duty is available.

* OWCP will ask the agency to send a copy of the employee's job description, including physical requirements, and a copy of his or her SF-171 or other employment application form. OWCP will request information about the employee's earnings and dependents periodically during the time of disability.

* When the medical evidence shows that total disability has ended, OWCP will advise the employee that he or she is expected to seek work. In accordance with 5 U.S.C. 8106, which provides for payment of compensation to partially disabled employees, OWCP will make every reasonable effort to arrange for employment of such employees. These efforts will concentrate initially on the agency, and only if reemployment with the agency is not possible will OWCP attempt to place the employee with a new employer.

LIGHT DUTY

Definition: A light duty position accommodates injured employees who are temporarily unable to perform their regular functions.

Advantages: A light duty program has several advantages for injured employees:

1. Light duty often accelerates recuperation.

2. A long layoff makes return to work more difficult.

3. While on light duty, employee still contributes to the organization and earn their pay.

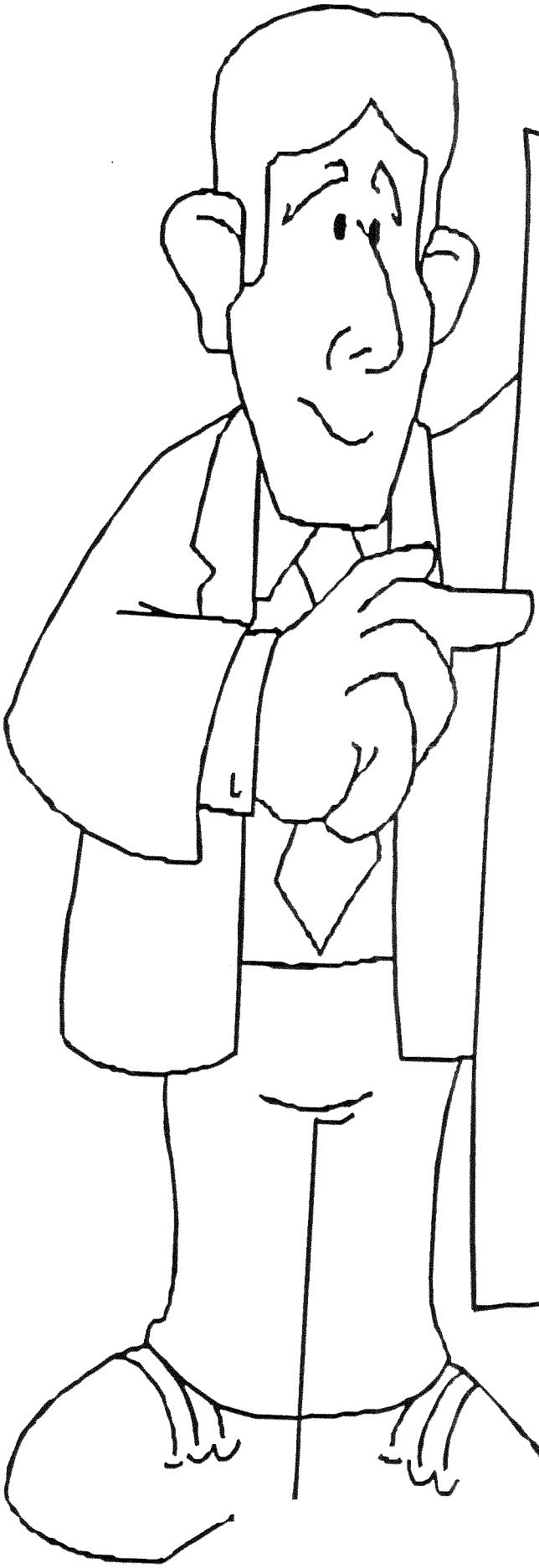
4. Since the employee is already working, they often prefer to return as soon as possible to their regular job, rather than continue doing lesser skilled light duty.

Procedure: When an injured employee cannot return to the job held at the time of injury but is no longer totally disabled, you will need to assist the employee to return to some other kind of work. Light duty is work with fewer physical demands than the employee's regular position.

The supervisor's first step is to determine the possibility of modifying the employee's regular job to meet his/her limitations. If this cannot be arranged, alternative work, preferably with no loss of wages, should be explored. This step can be initiated when the physician's report indicates the employee is no longer totally disabled. The employee is required to accept any reasonable offer of suitable light or limited duty.

Such an offer may be made by telephone but ***must*** be confirmed in writing in order to be valid. The employee must also reply in writing to the job offer. The offer must include a description of the duties and requirements of the offered position.

For further information on light duty, refer to FPM 810-Section 5-6 and 8-4.



IMPORTANT WORKERS' COMPENSATION NEWS

Since October 1, 2002, the workers' compensation processing and liaison services for the Department of Commerce has been provided by a private vendor, Contract Claims Services, Incorporated (CCSI, L.P.). Effective August 9, 2004, CCSI has a new physical address. In order to ensure timely claims submission, supervisors should use this address to **submit all initial claims (CA-1's and CA-2's)** and **claims for disability compensation (CA-7's)** by **Federal Express** to the new address:

CCSI, L.P.

300 E. Royal Lane
Suite 200

Irving, TX 75039

Employees and or supervisors should **send all other claims-related documents to** the current Post Office Box:

CCSI, L.P.

P.O. Box 542528

Dallas, TX 75354-2528

The contact numbers at CCSI, L.P., will remain the same:

Telephone: 1-800-743-2231

FAX: 1-888-467-1273

If you have any questions or concerns, please contact Kathy Mattingly at (202) 482-0689.

NOTE: THIS DOES NOT APPLY TO THE PATENT AND TRADEMARK OFFICE

Section 2

Safety Responsibilities for Supervisors

Occupational Safety and Health

Safety Responsibilities for Supervisors

Supervisors are key members of the Department's safety program. Safety responsibilities for supervisors are contained in several OSHA standards, as well as in the Department's Occupational Safety and Health Manual. To assist supervisors in carrying out their safety responsibilities, the key elements are described below:

Maintain safe and healthful workplaces: Keeping workplaces free from hazards is one of the most critical aspects of a comprehensive safety program. To ensure their employees are adequately protected from hazards, supervisors must:

• Monitor their workplaces frequently to identify unsafe or unhealthful conditions

• Take prompt action to correct hazardous conditions

• If a serious hazard is detected take immediate interim action to safeguard employees

• Encourage employees to report unsafe or unhealthful conditions

• Seek suggestions from employees for improvement of workplace conditions

Investigate workplace accidents:

• Investigate workplace mishaps and take prompt corrective action necessary to ensure the safety and health of employees

• Institute actions to prevent recurrence of accidents

Ensure employees are adequately trained to perform the work safely:

• Prior to permitting employees to work with machine tools, chemicals, powered machinery, electrical systems, lasers and other such equipment, or enter confined spaces, operate forklifts, work in elevated locations or perform similar hazardous work, they must receive specialized training. Contact the Safety Office to obtain the requirements for such training

• Inform employees of the hazards associated with the work they are to perform prior to beginning the work

• Inform employees of the requirements to use any personal protective equipment, such as respirators, safety glasses, fall protection, head or foot protection, etc.

- Inform employees of the procedures to follow in the event of an emergency
- Inform employees of any unique hazards in the workplace and how to identify them
- Inform employees of how to report unsafe or unhealthful conditions
- Inform employees of actions to take in the event of a work-related injury
- Maintain records of safety training provided, such as lesson plans, rosters, list of audio-visual and other materials used

Ensure that employees perform work in a safe manner:

- Monitor employee behavior to ensure that work is being performed safely
- Take prompt action to correct any unsafe or unhealthful actions or behavior

Section 3

Department Administrative Order 202-810

Workers' Compensation for Federal Employees

Number: DAO 202-810 **Effective Date:** 2004-11-24

SECTION 1. PURPOSE.

.01 This Order outlines authorities, establishes policies and describes responsibilities for administration and management of the centralized operation of the Workers' Compensation (WC) Program under the Federal Employees' Compensation Act.

.02 This is a general revision which: defines terms related to workers' compensation; identifies forms required for workers' compensation claims; and generally updates the Order.

SECTION 2. AUTHORITY.

.01 The authority for providing compensation benefits to Federal employees for injuries and illnesses sustained while in the performance of duty is governed by the Federal Employees' Compensation Act (FECA) as amended, 5 United States Code (USC) § 8101 et seq. This Act is administered by the Secretary of Labor.

.02 The administrative regulations implementing the FECA are set forth in 20 Code of Federal Regulations (CFR) Part 10.

SECTION 3. REFERENCES.

.01 The following references apply to this Order:

a. 29 CFR Part 1960, Basic Program Elements for Federal Employee Occupational Safety and Health Programs;

b. Department Administrative Order (DAO) 209-3, "Injury, Illness, Accident, and Fatality Investigation and Incident Reporting;"

c. Injury Compensation for Federal Employees, A Handbook for Employing Agency Personnel, Publication CA-810, prepared by the Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor.

SECTION 4. APPLICABILITY AND SCOPE.

This Order applies to all Department of Commerce (the Department) bureaus, agencies, offices, operating units, and other components.

SECTION 5. POLICY.

The Department is responsible for taking all appropriate steps necessary to obtain rightful benefits to eligible employees, their dependents or survivors; to assist them in processing claims and related documents in a timely, efficient manner; and to work closely with injured employees and supervisors to return the employee to work.

SECTION 6. DEFINITIONS.

.01 The following definitions are applicable to this Order:

a. Continuation of Pay (COP). The process by which an employee's regular pay may continue for up to 45 calendar days of wage loss due to disability and/or medical treatment after a traumatic injury. COP is not paid in cases of occupational illness.

b. Controversion. The process by which a supervisor or an agency recommends to the Department of Labor (DOL), Office of Workers' Compensation Programs (OWCP), that COP be denied.

c. Illness. A condition produced by the work environment over a period longer than a single workday or shift.

d. Light Duty. Those duties and responsibilities that are outside an employee's regular position, but that meet the employee's current work capabilities as identified by a physician. They may be performed for a full work shift or for shorter time periods.

e. Limited Duty. Those specific duties and responsibilities of an employee's regular position that meet the employee's current work capabilities as identified by a physician. These duties may include all or part of the employee's regular job assignment. They may be performed for a full work shift or for shorter time periods.

f. Medical Services. Services and supplies provided by or under the supervision of a physician. Reimbursable chiropractic services are limited to physical examinations and related laboratory tests, x-rays performed to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation.

g. Periodic Roll Claims. If medical reports indicate that disability will continue for at least 60 days after COP, OWCP places the employee on the periodic roll and payments are automatically paid by OWCP every 4 weeks with appropriate medical documentation.

h. Short Term Claims. Term for claims from the time of injury until employee is placed on the periodic roll.

i. Traumatic Injury. A condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.

SECTION 7. RESPONSIBILITIES.

.01 The Departmental Office of Human Resources Management (OHRM). The Director, OHRM or designated staff member serves as the Department's liaison officer with DOL. OHRM centrally administers the Department's WC Program and is responsible for program administration, management, operations, and the oversight of the workers' compensation contractor, Contract Claims Services, Incorporated (CCSI), as follows:

a. Establishing policies, procedures, and guidelines that ensure effective and efficient management of the WC Program including:

1. Claims Assistance - assisting and counseling employees with their periodic roll claims and coordinating with employees, supervisors and physicians to collect and send to DOL complete documentation when requested.

2. Leave Buy-Back - establishing guidelines for the repurchase of earned and advanced, sick and annual leave, which includes procedures for the submission and processing of applications.

3. Case Management - strategically managing periodic roll claims through monitoring medical evidence and work status.

4. Reemployment - pursuing job modification(s) or other means of enabling employees to work within their restrictions; requesting vocational rehabilitation assistance where indicated; and coordinating reemployment efforts with DOL, which may cross organizational lines and reach outside the agency.

5. Costs - reviewing and preparing cost reports for the Office of Financial Management (OFM) based on billing by the DOL, OWCP, for compensation benefits paid for work-related injuries and deaths.

b. Providing necessary liaison with DOL, including:

1. Reviewing DOL transcripts of hearings, and providing to DOL, relevant evidence and arguments supporting the Department's position, as appropriate.

2. Reviewing and reconciling charges for compensation benefits billed to the Department by DOL.

.02 Office of the Director for Financial Management (OFM). The OFM is responsible for:

a. Recording DOL charges in appropriate suspense account(s).

b. Issuing bills based on any distributions made by OHRM to appropriate operating units, at the lowest practicable level.

c. Maintaining appropriate records (subsidiary listing of charges and distributions for suspense accounts).

.03 Contract Claims Services, Incorporated (CCSI). The workers' compensation contractor for the Department, CCSI, is responsible for:

a. Claims Assistance - assisting and counseling employees in filing claims, and coordinating with employees, supervisors, and physicians to collect and send to DOL complete and accurate facts for timely adjudication of short terms claims.

b. Continuation of Pay (COP) - approving COP for injured employees and notifying supervisors to indicate COP, code 67, on employees' time and attendance records.

c. Leave Buy-Back - Preparing paperwork for DOL to process an employee's claim to buy back his/her leave.

d. Case Management - reviewing short term claims for compensation; challenging questionable claims; referring possible fraudulent claims to DOL; accommodating partially recovered injured employees by maintaining contact with them and their supervisor and affording limited duty, as warranted by the medical evidence.

.04 Supervisors and Managers. Supervisors and managers are responsible for:

a. Assisting an employee who has reported a work-related injury in obtaining medical attention as quickly as possible.

b. Ensuring that an injured employee is advised that workers' compensation guidance is available from CCSI and the Office of Occupational Safety and Health (OOSH) in OHRM.

c. Completing the supervisor's section of Forms CA-1 (for traumatic injury) and/or CA-2 (for occupational disease) and any other required DOL form in a timely manner, and in accordance with DOL operating guidance, and submitting such form(s) to CCSI. Also, completing Form CD-137, "Report of Accident/Incident," and providing a copy to the bureau's safety office.

d. Coordinating with the Department's contractor, CCSI, and the injured employee's timekeeper to modify the time and attendance reports for Continuation of Pay (COP) or compensation, as appropriate.

e. Providing all relevant information to CCSI in relation to questionable claims, and where appropriate, controverting COP in accordance with regulatory guidelines.

f. Providing any additional factual evidence to CCSI, as required by DOL in its adjudication of claims.

g. Maintaining contact with, and advising the employee of the availability of light and/or limited duty.

.05 Human Resources Offices may be requested to provide:

a. Personnel information required to establish eligibility for workers' compensation benefits.

b. Copies of health benefit enrollment forms to establish entitlement to Federal Employees' Health Benefits.

c. Retirement election forms.

d. Position descriptions or copies of personnel actions.

e. Information concerning the availability of light and/or limited duty jobs.

f. Assistance in reemploying an injured employee.

.06 Employees. Employees are responsible for:

a. Notifying the supervisor promptly of any work injury or occupational illness which has caused, aggravated, or adversely affected a medical condition.

b. Submitting the appropriate claim form to his/her supervisor within required time limits, as described on Form CA-1 and/or Form CA-2.

c. Establishing that the injury, or illness was causally related to factors of employment through the submission of factual and medical evidence which supports the claim filed.

d. Submitting claims for disability through his/her supervisor on a Form CA-7, "Claim for Compensation." The medical evidence submitted must support disability and/or medical treatment on the dates claimed.

e. Advising the supervisor promptly when the treating physician has medically released him/her to light and/or limited full duty.

.07 Other Claimants. Claimants for survivor benefits or for burial benefits are responsible for:

a. Submitting the appropriate claim form to the employee's supervisor within required time limits.

b. Establishing that the death was causally related to factors of employment through the submission of factual and medical evidence which supports the claim filed.

.08 Health Units. Health units are responsible for:

a. Providing first aid for all injured employees, upon request.

b. Referring injured workers for further medical treatment beyond the scope of the medical facility/health unit, at the request of the employee.

c. Issuing to an employee, or person designated to act on behalf of the employee, the appropriate DOL forms to report injury or illness.

.09 HCHB Health Unit. The HCHB Health Unit is responsible for:

a. Providing an assigned Health Unit physician (Medical Review Officer) to act as the Department's representative, as necessary, in obtaining information from referral physicians which is needed for review of OWCP cases.

SECTION 8. PROCEDURES.

.01 The supervisor will send all CA-1 and CA-2 claims for workers' compensation to CCSI within two working days of receipt. CCSI can be contacted at 1-800-743-2231.

.02 CCSI will:

a. Review claims for completion and forward them to DOL for adjudication.

b. Notify employees of receipt of claims and provide them information regarding their claims.

c. Prepare memorandum approving COP, when entitled.

d. Work with the Department, supervisors, employees, DOL, and medical providers to ensure that the employees are receiving all benefits to which they are entitled.

.03 DOL will:

a. Review claims and request any additional information needed to adjudicate them.

b. Accept or deny claims based on the information provided.

.03 Send all claims and documentation related to an employee's death in the performance of duty to OOSH, OHRM.

SECTION 9. FORMS.

.01 The following forms, as applicable, are required to establish a workers' compensation claim:

a. DOL Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation;"

b. DOL Form CA-2, "Notice of Occupational Disease and Claim for Compensation;"

c. DOL Form CA-5, "Claim for Compensation by Widow, Widower and/or Children;"

d. DOL Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren;"

e. DOL Form CA-6, "Official Supervisor's Report of Employee's Death;" and

.02 The following forms may be used in a workers' compensation claim:

a. DOL Form CA-7, "Claim for Compensation;"

b. DOL Form CA-16, "Authorization for Examination and/or Treatment;" and

c. DOL Form CA-20, "Attending Physician's Report."

SECTION 10. EFFECTS ON OTHER ORDERS.

This Order supersedes Department Administrative Order 202-810, dated September 23, 1997, and the provisions of all operating unit directives that prescribe authorities, responsibilities or policies related to workers' compensation.

Director for Human Resources Management

Approved:

_____

Chief Financial Officer and
Assistant Secretary for Administration

Office of Primary Interest
Office of Human Resources Management

Section 4

Department of Labor Office Workers' Compensation Program forms

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 job title
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 _____ State _____ ZIP Code _____

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) | OWCP Agency Code

OSHA Site Code

18. Employee's duty station (Street address and ZIP code) 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 31.)

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 witness? ☐ 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 t
☐ No lost t
☐ Lost time
☐ First Aid

cal folder (SF-66-D)
OWCP

Form CA-1
Rev. Apr. 1999

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
Booklet 2014, "Recordkeeping and Reportir

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

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

CA-1	THE UNOFFICIAL INSTRUCTIONS FOR COMPLETING: Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
	It is very important that all questions are answered and all blanks filled in. Enter N/A if the question is not applicable.
	The codes in the shaded areas will be completed by CCSI.
Item	**Information Required**
	TO BE COMPLETED BY EMPLOYEE:
1 - 8	Enter personal information. The Department of Labor (DOL) will not accept a claim if the Social Security Number and signature are not on the form.
9.	Enter the location of the injury
10.	Enter the date and time of injury.
11.	Enter the date that the form is being completed.
12.	Enter Job Title
13.	Explain the Cause of Injury - i.e., slipped and fell, lifted a 50 lb. Box and strained back, hit by a falling box, etc.
14.	Describe the injury and identify the body part that was injured.
15.	Check A or B, but not both. A. Continuation of Pay (COP) is your regular pay for up to 45 calendar days if disabled due to this injury. COP may also be used in lieu of sick leave for your medical appointment(s) pertaining to this injury. B. If this option is selected, leave will be used for any disability relating to this injury. Sign and date the form. To be eligible for COP, the CA-1 form must be completed and given to the supervisor within 30 days of the date of injury.

16.	Although this is not mandatory, if there was a witness to the accident/injury, ask them for a statement.
	COMPLETED CA-1 GOES TO THE SUPERVISOR FOR COMPLETION OF OFFICIAL SUPERVISOR'S REPORT
	TO BE COMPLETED BY SUPERVISOR:
	OWCP code and OSHA Site Code will be completed by CCSI
17.	CCSI's address, will be completed by CCSI
18.	Enter Duty Station Address -Don't forget the zip code.
19.	Check the employee's retirement coverage system.
20.	Scheduled hours of work. Work shifts can vary, so if the employee does not have a set schedule, indicate "Varies - works 8 hours daily" or the appropriate number of hours.
21.	Check all the boxes that apply.
22.	Enter Date of Injury.
23.	Enter the date you, the supervisor, actually received the signed CA-1 form - not the date you were verbally notified of the injury.
24.	Enter date and time the employee stopped work. If the employee did not stop work, enter N/A.
25.	This is usually N/A because the employee is most often covered by COP, sick and/or annual leave.
26.	The date the 45-day period begins is **never** the date of injury, but the first day missed from work following the date of injury.
27.	This is the date that employee returned to work after work stoppage.
28.	Check YES or NO. Please give details if you check NO.
29.	Enter YES or NO. If Yes, explain, i.e., intoxicated or fighting, etc.
30.	Third Party. Usually NO. If an employee was going to a meeting or training and was involved in an automobile accident that was not their fault, this would be a third party injury.

31.	If applicable, enter the name and number of responsible party, if not, enter N/A.
32.	Enter name and address of the treating physician if available. This information should be available on the medical report.
33.	Enter date employee first received medical treatment.
34.	Does the medical say the employee is disabled to work? YES or NO
35.	Please check YES or NO. If you check NO, explain why.
36.	If you received the CA-1 form within 30 days of the date of injury, enter N/A. If you received the form after 30 days from the date of the injury, enter YES - CLAIM NOT FILED TIMELY.
37.	Enter **yearly pay rate** or **hourly pay rate**.
38.	Enter name, signature, title, date signed and phone number.
39.	Be sure to check one of these boxes.
	Attached to the CA-1 form is a Receipt of Notice of Injury. Complete the information and give the page to the employee. This is acknowledgment that you, the supervisor, received their claim.
	Send completed form and all available back up information within 2 days to: CCSI, L.P. 300 E. Royal Lane Irving, TX 75039 TO ENSURE THAT CLAIMS ARE SUBMITTED TIMELY, PLEASE SEND BY FEDERAL EXPRESS. **Send all back up information as soon as available.** **If you are unable to send the original form by Federal Express, please fax the form and other available information to CCSI at 1-888-467-1273 and send the originals and other back up information as soon as you can.**

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 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 imprisonment or both.

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

Supervisor's Report

19. Agency name and address of reporting office (Include city, state, and ZIP Code) | OWCP Agency Code

OSHA Site Code

ZIP Code

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

21. Regular work hours From: ☐ 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

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) Deailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

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

Supervisor (Or appropriate official in the employing agency)

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

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

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

Item Explanations: Some of the items on the form which may require further clarification are explained below.

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

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

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

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

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

32. Employee's Retirement Coverage.
Indicate which retirement system the employee is covered under.

Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be
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OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

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

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

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

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

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

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

Privacy Act

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

Receipt of Notice of Occupational Disease or Illness

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

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

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

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

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 Base Pay

Date of Injury:	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), Quarters (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 2 From 5/21 to 5/27		8		6	6		4

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

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

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

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

a. Health Benefits under the FEHBP? ☐ No ☐ Yes Code ☐☐☐

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Life 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	If intermittent, complete Form CA-7a, Time Analysis Sheet.
Annual Leave	From ___/___/___	To ___/___/___	☐ Yes ☐ No	
Leave without Pay	From ___/___/___	To ___/___/___	☐ Yes ☐ No	If leave buy back, also submit completed Form CA-7b.
Work	From ___/___/___	To ___/___/___	☐ 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 ___ *(Agency Official)* Title ___ Date ___/___/___

Name of Agency ___

If OWCP needs specific pay information

Name ___

Telephone No. ( ) -

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: 08/31/2002

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

c. OWCP File Number

d. Date of Injury
Month Day Year

E-Mail Address *(Optional)*

e. Social Security Number

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

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

☐ Yes Name and Address of Business:

☐ No *Go to Section 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?

☐ 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)

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 _____ *year)* _____

Form CA-7
Rev. Nov. 1999

INSTRUCTIONS FOR COMPLETING FORM CA-7

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

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

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

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

SUPERVISOR (or appropriate official in the employing agency) — Complete sections 8 through 15 as directed and promptly forward the form to 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-time student; or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

Public Burden Statement

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

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

FORM CA-20, PHYSICIAN'S REPORT

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

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

PRIVACY ACT

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

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

*U.S. Government Printing Office: 2000 — 467-970/39570

CA-7	THE UNOFFICIAL INSTRUCTIONS FOR COMPLETING: Claim for Compensation
Item	**Information Required**
	TO BE COMPLETED BY EMPLOYEE:
Section 1	**Personal Information**
a-f	Enter personal information. Be sure to complete the information in all blocks.
Section 2	**Check the appropriate box to claim compensation.**
a.	If you are in a **Leave Without Pay Status** and you are claiming compensation, enter the dates.
b.	If this form is to **Buy Back Leave** that you used for disability due to your work injury, enter the dates. If the dates are not consecutive, complete Form CA-7a, which is a form to identify the dates and hours missed from work.
c.	List dates of **Other Wage Loss.**
d.	If your disability results in a permanent loss or loss of use of certain members and functions of the body and you are requesting a **Schedule Award**, check this box. The Department of Labor (DOL) will send you a letter to give to your physician so you may be evaluated for the percentage of disability.
Section 3	**Non-Government Wage Loss**
	Provide the information requested if you held a non-government job during the period claimed in Section 2.
Section 4	**Check the appropriate box**

	If this is the first form CA-7 being filed for this injury, check **YES**. If not, check **NO**. If you checked **NO**, check **YES** if your dependent information has changed, or **NO** if it has not. The Direct Deposit Form SF-1199a is not mandatory. However, DOL will mail you a check if you do not have direct deposit. It is more convenient and faster for DOL to transfer funds into your account with direct deposit. You can get the Direct Deposit Form from your banking facility.
Section 5	**Dependent Information. This information sets your compensation rate, 75% with dependents and 66 2/3% without dependents.**
	Provide the requested information for each dependent. If you do not have dependents, enter N/A. Check the appropriate box for questions a and b.
Section 6	**3rd Party Information**
a.	Check the appropriate box for a third party claim.
b.	Check the appropriate box for veteran benefits and provide the requested information, if applicable.
c.	Check the appropriate box for Federal Retirement or Disability law and provide the requested information, if applicable.
Section 7	**Sign and date the claim form and give it to your supervisor for completion of Sections 8 - 15.**
	TO BE COMPLETED BY SUPERVISOR:
Section 8	**Pay Information**
	This information regarding the pay rate is important and must be completed to identify the pay rate for compensation.
	Enter the date of injury and the pay rate at the time of injury, the grade and step. Enter any additional pay elements that the employee is routinely paid. **Overtime is not compensable.**

	Enter the date the employee stopped work and the pay rate at that time. This may be a duplicate of the first pay information entered, but please re-enter it.
Section 9	**Work Schedule**
a.	Check YES or NO - Please write in the work week, then move to the Week 1 and 2 and enter the appropriate information.
b.	Did the employee work in the current position for 11 months prior to the injury. Check YES or NO.
Section 10	**Health and Life Benefit Information**
	Enter the requested information for health benefits, life insurance and type of retirement. This information is important so that the premiums for health and life insurance may be deducted from the compensation check in order to continue their coverage without any break in service.
Section 11	**Continuation of Pay Dates**
	If continuation of pay was given to the employee, enter the dates. If the dates were not consecutive, complete Form CA-7a, identifying the days missed from work.
Section 12	**Pay status for period claimed**
	This block corresponds to the dates the employee claimed in Section 2. Check the employee's T&A's to verify the dates and hours claimed.
Section 13	**Return to Work**
	Has the employee returned to work? If so, identify any change in his/her duties and work hours.
Section 14	**Remarks**

	This space is provided for any additional information you would like to provide regarding the claim for wage loss.
Section 15	Sign the form and enter the appropriate information requested.
	Send completed form and all available back up information to: CCSI, L.P. 300 E. Royal Lane Irving, TX 75039 TO ENSURE THAT CLAIMS ARE SUBMITTED TIMELY, PLEASE SEND BY FEDERAL EXPRESS. If you are unable to send the original form by Federal Express, please fax the form and other information to CCSI at 1-888-467-1273 and send the originals as soon as you can.

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, gatherin the collection of information. If you have any comments regarding these ling suggestions for reducing this burden, send them to the Office of Worker), 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM

Form CA-16
Rev. Jan. 1997

PART B - ATTENDING PHYSICIAN'S REPORT

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

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

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ 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 any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

MEDICAL BILL: Charges for your services s
OWCP-1500a, or HCFA 1500). Service must

rom" (AMA OP 407/408/409;
he form must be signed.

For sale by the Supe

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 issued 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 compelted 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 B. 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

(FPM).

INFORMATION . JR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authoreized 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.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accomodations 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 supplid 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 identifier 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:1997-418-422/62712

CA-16	THE UNOFFICIAL INSTRUCTIONS FOR COMPLETING: Authorization for Examination and/or Treatment
Item	**Information Required**
1.	Enter the doctor's name or the hospital where you are sending the employee - **DO NOT LEAVE BLANK**
2.	Enter employee's name.
3.	Enter Date of Injury
4.	Enter job title
5.	Give a brief description of the injury - i.e. fell and injured ankle, cut hand with a knife, lifted a 50 pound box and hurt back
6.	Be sure to check a block under "B". If there is **no** doubt of an injury - check 1. If you are not sure an injury actually occurred - check 2.
7.	Enter N/A
8.	Sign the form. It is not valid unless signed.
9.	Enter your name and title.
10.	Enter your phone number.
11.	Enter the date.
12.	Have the form mailed to: CCSI, L.P. P.O. Box 542528 Dallas, TX 75354-2528
13.	Enter DOC/Agency Name and address
	Give the form to the employee to take to the medical provider. The doctor completes Part B, Attending Physician's Report. If the form is not completed for the injured employee at the time of treatment, have the doctor fax a copy to CCSI at 1-888-467-1273 and mail the original to the above address.

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.). 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.

OMB No. 1215-0103
Expires. 9-30-91

Instructions for Completing and Submitting this Form

Supervisor: Complete Part A and refer the form to the attending physician for completion of Part B.

Attending Physician: Complete Part B. To prevent interruption of the employee's pay, the completed form should be returned to the employing agency (as shown in Item 12) within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in Item 11).

Part A - Supervisor

1. Name and Address of Medical Facility Providing Medical Services.

2. OWCP File Number (If known)

3. Employee's Name (Last, first, middle)

4. Date of Injury (Month, day, yr.)

5. Social Security No

6. Occupation

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

8. 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.

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0-10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10-20 lbs.			Hrs Per Day	q. Reaching above Shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20-50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying: Heavy 50-100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify)			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise (Give dBA)			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Other (Describe)			Hrs Per Day
k. Bending			Hrs Per Day				
l. Stooping			Hrs Per Day				
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

9. Does the Job Require Driving a Vehicle

☐ Yes (Specify) ☐ No

Operating Machinery?

☐ Yes (Specify) ☐ No

10. The Employee Works

Hours Per Day

Days Per Week

11. Send A Copy of This Report To:

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

12. Send the Original Report to (Name and Address of Employing Agency):

Public Burden Statement

Public reporting burden for this collectior instructions, searching existing data sourc information. Send comments regarding th reducing burden, to the Office of Infor Washington, D.C. 20210; and to the Office

including time for reviewing nd reviewing the collection of ition, including suggestions for Constitution Avenue, N.W., dget, Washington, D.C. 20503.

For sale by the U.S. Gove

20402-9328

Form CA-17
Rev. Oct. 1988

Part B - Physician

13a. Does the History of Injury Given to You by the Employee Correspond to That Shown in Item 7?

☐ Yes ☐ No (If not, describe)

13b. Description of Clinical Findings

13c. Diagnosis of Condition Due to Injury

13d. Diagnosis of Other Disabling Conditions

14. Is Employee Able to Perform His/Her Regular Work (Describe on the Front of This Form)?

☐ Yes, If So, ☐ Full-Time or ☐ Part-Time _____ Hours Per Day (Fill In)

☐ No, If not, complete item 15 below.

15. Complete the Following, If The Answer To Item 14 is "No".

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying Sedentary 0-10 lbs.			Hrs Per Day	p. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying Light 10-20 lbs.			Hrs Per Day	q. Reaching above shoulder			Hrs Per Day
c. Lifting/Carrying Moderate 20-50 lbs.			Hrs Per Day	r. Heat			degrees F
d. Lifting/Carrying Heavy 50-100 lbs.			Hrs Per Day	s. Cold			degrees F
e. Sitting			Hrs Per Day	t. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	u. Chemicals, Solvents etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	v. Fumes (Identify)			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	w. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	x. Noise (Give dBA)			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	y. Are Interpersonal Relations Affected Because of A Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.)			
k. Bending			Hrs Per Day				
l. Stooping			Hrs Per Day	☐ No ☐ Yes (Describe)			
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

16. Describe Any Other Function of This Employee's Regular Work Which is Medically Restricted By The Injury.

17. Period of Disability (If termination date is unknown, so state)

Total Disability From To

Partial Disability From To

18. If Employee is Able to Resume Work, Has He/She Been Advised?

☐ Yes ☐ No

If Yes, Give Date of Advice _____

19. Date of Examination

20. Date of Next Appointment, If Scheduled

I certify that all statements made above are true. I understand that any knowingly false or misleading statement, or misrepresentation of material fact may subject me to felony criminal prosecution. I further understand that expenses related to this medical care are payable by the Office of Workers' compensation Programs only if the condition treated is deemed by OWCP to be covered under the Federal Employees' Compensation Act, or the treatment was otherwise authorized by a U.S. Government official.

21. Typed or Printed Name and Address of Physician

22. Specialty

23. Tax Identification Number

25. Date

FFICE : 1994 0 - 154-760

Attending Physician's Report

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

Record of Examination

1. Patient's name Last First Middle
2. Date of Injury mo. day yr.
3. OWCP File Number

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

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

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe)
☐ Yes ☐ No

ICD-9 Code

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

7. What is your diagnosis?

ICD-9 Code

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

9. Did injury require hospitalization? If no, go to item #13
☐ Yes ☐ No

10. Date of admission mo. day yr.

11. Date of discharge mo. day yr.

12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.

15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.

16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.

18. Period of Partial Disability From mo. day yr. Thru mo. day yr.

19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.

21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No

22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)

24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State ZIP

Specialty

27. What was the reason for this referral?
☐ Consultation ☐ Treatment

Signature

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

Signature of Physician _____ Date _____

29. Name of Physician

Address

City S

30. Tax ID Number

31. Do you specialize? ☐ Yes ☐ No

dicate specialty

Form CA-20
Rev. Nov. 1999

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

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

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

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

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

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

For Sale by the

Claimant Medical Reimbursement Form

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

NOTE: This report is authorized by law. Disclosure of your Social Security Number is voluntary. Failure to disclose this number will not result in the denial of any right, benefit or privilege to which you may be entitled. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir.No. 108. This form is only to be used for requesting reimbursement of medical expenses payable under the Federal Employees' Compensation Act (FECA) (20 CFR 10.802).

OMB No.: 1215-0193
Expires: 01/31/2004

1. Claimant's Name (Last, First, MI)	2. Claimant's Social Security Number (Optional)
3. Claimant's OWCP Case File Number	4. Claimant's Telephone Number

5. Claimant's Address (Number and Street/RFD, City, State, ZIP Code)

SPECIAL INSTRUCTIONS:

1. See reverse side of form for COMPLETE INSTRUCTIONS AND REQUIREMENTS FOR ATTACHMENT OF BILLS/RECEIPTS.
2. Please list below only charges that you paid related to medical services covered under the Federal Employees' Compensation Program.
3. Use a separate line for each type of service.

6. Name of Provider Making the Charge (Doctor, Hospital, Pharmacy, etc.)	Description of Charge (name of prescription drug, office visit, durable med. equipment e.g., back brace, TENS unit, etc.)	Date of Service or Purchase (Month, day, year, if there is only one date, show it under "From")		Amount Paid by Claimant	FOR DOL USE ONLY
		From	To		

Total amount paid by Claimant:

I certify that the information above is correct and that reimbursement requested is for expenses paid by me for treatment of my work-related condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain compensation under the FECA is subject to criminal prosecution and may be punished by a fine of not more than $10,000 or imprisonment for not more than five years, or both.

I authorize any provider named above to release information to the Office of Workers' Compensation Programs, Division of Federal Employees' Compensation if necessary for the proper adjudication of this claim.

Payee's Signature: _____ Date: _____

MAIL THIS COMPLETED FORM WITH ITEMIZED BILLS AND RECEIPTS SECURELY ATTACHED TO YOUR SERVICING OWCP/DFEC OFFICE.

INSTRUCTIONS FOR USE OF FORM CA-915

USE OF THIS FORM: This form is used to seek reimbursement for medical expenses (other than travel) incurred in the treatment of the condition(s) accepted by OWCP as work-related under the Federal Employees' Compensation Act.

INFORMATION REQUIRED FOR REIMBURSEMENT OF MEDICAL EXPENSES:

1. Pharmacy drugs:

Pharmacy must complete the Universal Drug Claim Form (NCPDP Form 79-1A) or equivalent, which must be attached to this form (CA-915) and must include the following:

Pharmacy's name, address and tax identification number (I.R.S. No.).

Claimant's name, address and OWCP claim number.

Name of physician who prescribed the drug(s).

Eleven digit National Drug Code (NDC).

Date filled.

Name of drug and strength.

Quantity (amount prescribed, expressed as the total number of tablets/capsules dispensed per prescription or total ml or cc per prescription for liquids).

New prescription or refill number.

Amount actually paid by claimant.

2. Medical expenses other than pharmacy drugs.

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 UB-92. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount actually paid by the claimant must be included. The Form OWCP-1500 or UB-92 must be attached to this Form (CA-915).

3. Travel.

Claims for travel reimbursement should be submitted on SF-1012, "Travel Voucher," not on Form CA-915. Instructions for submitting travel vouchers are found in Instruction CA-77.

4. Proof of payment requirements.

The following information is required as evidence that the claimant paid all or a portion of the bill:

- an itemized bill from the provider containing the information listed above, the original signature of the provider, and the amount paid by the claimant, or
- the provider's official receipt signed by the provider, indicating date(s) and specific services(s) rendered and the amount paid by the claimant.

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching for existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of the Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Medical Travel Refund Request

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

NOTE: This report is authorized by the Black Lung Benefits Act (30 USC 901, 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act (Public Law 106-398 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 services covered under the Federal Black Lung Program and the Energy Employees Occupational Illness Compensation Program.

OMB No. 1215-0054
Expires: 06/30/2004

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

2. Social Security 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) _____

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)

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 also fully aware that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year or both.

Claimant's/Payee's Signature: Date:

Form OWCP-957
Rev. Aug 2001

Instructions (Form OWCP-957)

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

2. Enter claimant's Social Security Number.

3. Enter payee's full name (if person other than the minor or 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.

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 round trip.
- To obtain your district office telephone number, 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 travel exceeding 75 miles one way or 150 miles round trip. 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 res ently valid OMB control number.

Office of Occupational Safety and Health

Fred Fanning HCHB, 14th & Penn Avenue Washington, DC 20230 (202) 482-0211 ffanning@doc.gov	Camille Carraway HCHB, 14th & Penn Avenue Washington, DC 20230 (202) 482-1990 ccarraway@doc.gov Department Safety and Health Program Industrial Hygiene HCHB Health Unit
Katherine Mattingly HCHB, 14th & Penn Avenue Washington, DC 20230 (202) 482-0689 kmattingly@doc.gov Workers' Compensation Specialist	April Prather-Nichols HCHB, 14th & Penn Avenue Washington, DC 20230 (202) 482-6370 aprather-nichols@doc.gov Department Safety and Health Program Department Safety and Health Training
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Adrienne Ross HCHB, 14th & Penn Avenue Washington, DC 20230 (202) 482-4943 aross@doc.gov Safety Specialist Workers' Compensation Program	

Glossary

Acceleration: A work related injury or disease may hasten the development of an underlying condition

Aggravation: Preexisting condition worsened, either temporarily or permanently, by a work related injury

Compensation: The reimbursement to employee of lost wages, medical bills, and death benefits as a result of a work place injury or illness.

Continuation of Pay: The payment of benefits to an employee who has been approved for these benefits as a result of a workplace injury or illness. This is paid for traumatic injuries only, not to exceed 45 calendar days, claim must have been filed within 30 days of injury, and the employee must have supporting medical documentation

Death Benefits: Paid to an employee or eligible survivors. Must be from a work injury/exposure resulted in death, 50% paid to surviving spouse, 15% paid to each child with the total not to exceed 75% of base salary

Direct Causation: Injury or factors of employment result in condition claimed

Light Duty: A light duty position accommodates injured employees who are temporarily unable to perform their regular functions.

Medical Benefits: The payment of medical bills related to the work place injury or illness. The employee has their choice of physician, there is limited chiropractic coverage, doctor bills are paid under fee schedule, prescriptions are reimbursed, mileage to/from physician is paid, and physician ordered equipment is provided.

Occupational Disease: A condition that develops over more than one work shift

Periodic Rolls: A claim that continues for more than 60 days.

Preventive Care: Medical care received before an injury. This is not authorized under this program.

Precipitation: A latent condition that would not have manifested itself on this occasion but for employment

Rehabilitation: Services provided to an injured or ill employee that is on the long-term disability rolls. This may consist of job training/job placement, schedule award, permanent loss/loss of use, and is for a specified period of time.

Reimbursement for wage loss: Is paid by the Department of Labor and charged back to employer. The employee receives 75% of their former pay with dependents and 66 2/3% of their former pay without dependents.

Single Criterion: Length of time of exposure.

Traumatic Injury: An injury that occurs during one work shift.