WORKERS' COMPENSATION GUIDANCE FOR DEPARTMENT OF THE INTERIOR PERSONNEL

For additional information or guidance, please contact:
Carmen M. Craddock, Workers' Compensation Program Manager,
Department of the Interior, (202) 208-0144

DISCLAIMER

Materials adapted from the Department of Labor's "A Handbook for Employing Agency Personnel", Publication CA-810, (Rev. Feb. 1994)

 This material will be made available to sensory impaired individuals upon request. Voice phone: 202-219-8743 TDD phone: 1-800-326-2577 (Telecommunications Device for the Deaf). This material was adapted from materials prepared by the Office of Workers' Compensation Programs (OWCP), Employment Standards Administration, United States Department of Labor. It is meant to serve as a handbook for the Department of the Interior workers' compensation specialists and supervisors (the term "supervisor" is used generically to refer to individuals in all of these roles). For information concerning any aspect of the program which is not addressed in this manual, contact the OWCP district office which serves your region.

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CHAPTER 1. OVERVIEW

This chapter provides basic information concerning the administration of the Federal Employees' Compensation Act (FECA).

1-1. Purpose

The FECA provides compensation benefits to civilian employees of the United States for disability due to personal injury or disease sustained while in the performance of duty. The FECA also provides for the payment of benefits to dependents if a work-related injury or disease causes an employee's death. The FECA is intended to be remedial in nature, and proceedings under it are non-adversarial.

1-2. Exclusiveness of Remedy

Benefits provided under the FECA constitute the sole remedy against the United States for work-related injury or death. A federal employee or surviving dependent is not entitled to sue the United States or recover damages for such injury or death under any other statute.

1-3. Office of Workers' Compensation Program (OWCP) Structure

Department of Labor's Office of Workers' Compensation Programs, Division of Federal Employees' Compensation (DFEC) administers the FECA. The Director of the program, in conjunction with regional managers, has authority over the operations of the 12 district offices. Each of these offices is headed by a District Director, who has overall responsibility for office functions.

In each district office are two or more Supervisory Claims Examiners, who are responsible for the operation of individual claims units, and a number of Senior Claims Examiners and Claims Examiners, who have primary responsibility for handling claims. Individuals at each level of authority from Claims Examiner to District Director have been delegated specific responsibilities for issuing decisions on claims.

1-4. Jurisdiction

The jurisdictions of the 12 district offices are as follows (See Appendix C for addresses):

- *District 1*: Boston, MA: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.
- *District 2:* New York, NY: New Jersey, New York, Puerto Rico, and the Virgin Islands.
- *District 3:* Philadelphia, PA: Delaware, Pennsylvania, and West Virginia.
- *District 6*: Jacksonville, FL: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.
- *District 9:* Cleveland, OH: Indiana, Michigan, and Ohio.
- *District 10:* Chicago, IL: Illinois, Minnesota, and Wisconsin.

- *District 11:* Kansas City, MO: Iowa, Kansas, Missouri, and Nebraska; Department of Labor employees.
- *District 12:* Denver, CO: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming.
- *District 13:* San Francisco, CA: Arizona, California, Hawaii, and Nevada; Pacific territories and possessions.
- *District 14*: Seattle, WA: Alaska, Idaho, Oregon, and Washington.
- *District 16:* Dallas, TX: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.
- *District 25:* Washington, DC: Maryland, Virginia, the District of Columbia; employees injured overseas; employees claiming injury due to radiation, Agent Orange, or HIV infection; Peace Corps and Volunteers in Service to America (VISTA) workers; Members of Congress and their staffs; White House officials and employees; Reserve Officer Training Corps (ROTC) Cadets; members of the Coast Guard Auxiliary and temporary members of the Coast Guard Reserve; employees whose cases involve security considerations; and certain non-federal claims.

1-5. Information and Records

Individual case files are protected under the Privacy Act, and only the employee, his or her representative (if any), and Department of the Interior (hereafter, agency) personnel may routinely have access to the file. Any of these parties may inspect the file at the district office which has custody of the file; an appointment should be requested ahead of time. If it is not possible to inspect the record at the district office, arrangements may be made to have the case sent to another Department of Labor office for review.

Employees and their representatives may have access to records (including medical reports) which OWCP has released to the agency from the case file. The records must, however, be safeguarded in the same manner as other personnel material. Each agency is responsible for determining whether such information may properly be released in accordance with the regulations contained in 29 CFR parts 70 and 71.

As stated in OWCP's regulations, while an employer may establish procedures for an injured employee or beneficiary to obtain documents, any decision issued in response to such a request must comply with OWCP's regulations, no employer may correct or amend records pertaining to OWCP claims.

1-6. Penalties

The regulations at 20 CFR 10.23 provide that:

A. Any person who knowingly makes, or knowingly certifies to, any false statement, misrepresentation, concealment of fact, or any other act of fraud with respect to a claim under the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate U.S. Criminal Code provisions (e.g., 18 USC 287 and 1001), be punished by a fine of not more than $10,000 or imprisonment for not more than five years, or both.

B. Any person who, with respect to a claim under the FECA, enters into any agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain the payment or allowance of any false, fictitious or fraudulent claim is subject to criminal prosecution and may, under appropriate U.S. Criminal Code provisions (e.g., 18 USC 286), be punished by a fine of not more than $10,000 or imprisonment for not more than 10 years, or both.

C. Any person charged with the responsibility of making reports in connection with an injury who willfully fails, neglects, or refuses to do so; induces, compels, or directs an injured employee to forego filing a claim; or willfully retains any notice, report, or paper required in connection with an injury, is subject to a fine of not more than $500 or imprisonment for not more than one year, or both. Moreover, claimants convicted of fraudulently claiming or obtaining benefits under FECA on or after October 21, 1993, the effective date of Public Law 103-112, will lose entitlement to medical benefits, compensation for wage loss, and any other benefits payable under the FECA.

1-7. References

Several resources describing the provisions of the law and how they are applied are available.

A. The Federal Employees' Compensation Act (FECA) as amended, 5 USC 8101 et seq., is the source of entitlement to compensation benefits for federal workers. Because virtually all of the provisions of the FECA have been interpreted and more fully described through OWCP directives and decisions of the Employees' Compensation Appeals Board (ECAB). For this reason, the program's Procedure Manual and ECAB decisions will usually prove more helpful than the Act itself, which may be obtained from OWCP's website at http://www.dol.gov/esa/regs/statutes/owcp/owcpstat.htm.

B. The Code of Federal Regulations, 20 CFR Chapter 10, Part A, more fully describes the provisions of the law and contains additional information concerning administration of the program. References to the regulations

may occasionally be found in letters and decisions of OWCP. Copies may be obtained from OWCP's website at http://www.dol.gov/esa/regs/statutes/owcp/owcpstat.htm.

C. The Federal (FECA) Procedure Manual describes in detail the procedures used by OWCP personnel in processing claims. It is divided into several sections by subject area; the section most likely to be of use to agency personnel is Part 2, Claims. Interested parties may obtain it for $35 per copy from the Division of Federal Employees' Compensation Office of Workers' Compensation Programs, 200 Constitution Avenue N. W., Room S-3229, Washington, D.C. 20210. Alternatively, copies may be downloaded from the DOL's website at http://www.dol.gov/esa/regs/compliance/owcp/.

D. Questions and Answers about the Federal Employees' Compensation Act (Pamphlet CA-550) describes in non-technical language the basic provisions of the law and includes information concerning the most common issues about entitlement and claims processing. It is intended for use primarily by employees, who may obtain single copies from OWCP's website or from the district office (there is no charge). Agencies may order copies from GPO at the address shown in Chapter 1-7 or online at http://www.dol.gov/esa/regs/compliance/owcp/INDEXofResources.htm.

E. Decisions of the Employees' Compensation Appeals Board may be found in most law libraries. Recent decisions are available from DOL's website, and all decisions are available on a CR-ROM which may be purchased from Howe Data Inc, or in bound volumes which may be purchased from GPO. Alternatively, these decisions are also available online at http://www.dol.gov/esa/regs/compliance/owcp/.

F. The Safety Management Information System (SMIS) is the Department of the Interior's web-based, safety and health recordkeeping system. SMIS has been designed to allow direct electronic filing of workers' compensation claims with the Department of Labor. Electronic filing is intended to provide faster service to injured employees and their families. SMIS also enables all supervisors, managers, safety officers, and human resources staff to carry out their responsibilities for accident reporting and workers' compensation case management. The system contains a variety of resource materials such as a reference library, "SafetySmart Online", DOI Safety Statistics, as well as performance metrics for the Safety, Health And Return-to-Employment (SHARE) Initiative with which employees may wish to become familiar. Additionally, the SMIS website contains three electronic "SMIS User's Guides" and Powerpoint presentations are available on-line for supervisors, managers, employees, and Workers' Compensation Program Specialists. SMIS is accessed at: http://www.SMIS.doi.gov/.

1-8. Forms

Agencies should maintain an adequate supply of the basic forms needed to process claims, as follows:

Form	Title
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay
CA-2	Federal Employee's Notice of Occupational Disease and Claim for Compensation
CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay
CA-3	Report of Termination of Disability and/or Payment
CA-5	Claim for Compensation by Widow, Widower and/or Children
CA-5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents/children
CA-6	Official Superior's Report of Employee's Death
CA-7	Claim for Compensation on Account of Traumatic Injury/Occupational Disease
CA7a	Time Analysis Form
CA-7b	Leave Buy Back (LBB) Worksheet Certification and Election
CA-8	Claim for Continuing Compensation on Account of Disability
CA-16	Authorization for Examination and/or Treatment
CA-17	Duty Status Report
CA-2	Attending Physician's Report (attached to Form CA-7; also available separately)
CA-35, a-h	Occupational Disease Checklists
OWCP-1500a	Health Insurance Claim Form

Forms may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D. C. 20402. The purchase order must include Interior's appropriation symbol and the requestor's signature. Forms may also be ordered by telephone at (202) 783-3238 or at OWCP's website: http://www.dol.gov.dol/esa/owcp.htm. Also copies of these forms are listed in Appendix A for reference.

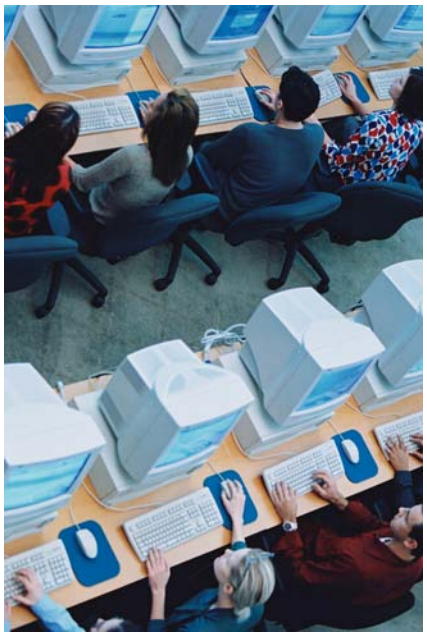
1-9. Training

OWCP has developed several kinds of instructional materials to assist agencies in processing compensation claims. The following courses are provided in response to requests from agency personnel:

A. The FECA Seminar provides an overview of the law for first line supervisors as well as middle and senior level managers. The seminar, which is comprised of lectures and visual aids, may range from one to six hours, and it may be given for either small or large groups. The seminar is usually held at the requesting agency and may be given to single or multi-agency groups as well as to federal labor unions.

B. The Basic Compensation Specialist Workshop provides a three day formal training session in a classroom setting. It is intended for agency personnel who are primarily responsible for processing OWCP claims and for those who spend at least 50% of their time handling OWCP claims. The training stresses skills needed to counsel injured employees, review claim forms for accuracy, document continuation of pay, and develop a record-keeping system.

C. The Advanced Compensation Specialist Training is a self-instructional unit requiring approximately 12 hours to complete. It is primarily intended for compensation specialists who have attended the basic course and who have nine to twelve months of experience. The course stresses management of agency compensation case files with regard to third party matters, review of chargeback reports and billings, light duty assignments, and reemployment of the long-term disabled.



D. The FECA Supervisors Workshop is tailored to meet the needs of the agency requesting training. The training generally covers supervisory responsibilities to employees who are injured at work. It includes reviewing initial reporting forms; counseling employees about continuation of pay (COP); determining whether the claim should be controverted; and offering light duty assignments for injured employees. The length of this course varies according to the kind and amount of material presented.

Arrangements for delivery of these courses may be made with the Technical Assistant or Communication Specialist of the district office serving your agency.

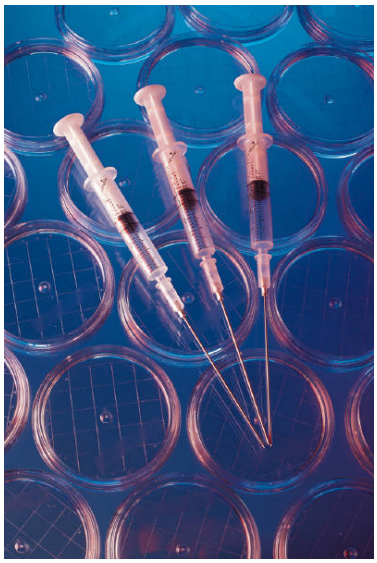
CHAPTER 2. INITIATING CLAIMS

This chapter describes the difference between exposure to an infectious agent, which is not compensable, and actual injury. The forms and procedures to be used by employees and agency personnel in initiating claims for traumatic injury, occupational disease, recurrence of disability, and death are then outlined. ***DOI personnel are cautioned never to prevent employees from filing claims under any circumstances.***

2-1. Exposure to Infectious Agents

The FECA does not provide for payment of any expenses associated with simple exposure to an infectious disease, without the occurrence of a work-related injury. Such infectious disease may include tuberculosis, hepatitis, and HIV (human immunodeficiency virus).

Under regulations published by the Occupational Safety and Health Administration addressing the health risks posed by blood borne pathogens in the workplace, an "exposure incident" is defined as a "specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties" (29 CFR 1910.1030). Both a work-related injury and exposure to a known carrier must occur before OWCP can pay for diagnostic testing. A puncture wound from a needle used to draw blood from a patient not known to be infected with HIV would entitle the worker to benefits only for the effects of the puncture wound, and the supervisor would not issue Form CA-16 to authorize precautionary testing since no indication exists that a communicable disease has been contracted on duty. However, a puncture wound from a needle used to draw blood from a patient who was known to be infected with HIV would entitle the worker to benefits for the effects of the puncture wound and to payment for diagnostic studies to rule out the presence of a more serious condition, because exposure to a known carrier would be involved.



Similarly, fear of exposure to an infectious agent does not entitle the worker to benefits under the FECA since no definable injury has occurred. For instance, the act of searching an individual known to have hepatitis, or an individual who is believed to belong to a high-risk group for HIV infection, would not entitle an employee to benefits. In these situations, the supervisor should not issue Form CA-16 as no injury or exposure has occurred.

However, employees who have encountered persons with HIV infection may suffer anxiety for their health, and employing agencies should take these concerns seriously when actual exposure (as opposed to fear of exposure) has occurred. In such cases, the supervisor may use the authority provided by 5 USC 7901 to

authorize testing or counseling. This section of the law allows agencies to provide screening and associated health services to their own employees, and the services offered may be geared to the particular occupational hazards to which an agency's employees are commonly exposed.

It may also be useful to consider performance of surveillance testing, which monitors a population at risk for a certain condition (as opposed to diagnostic testing, which is performed to assess the specific nature of an individual's illness when a medical condition is known to exist). To arrange for HIV testing or employee counseling, you may wish to contact the appropriate regional office of the Public Health Service.

2-2. Traumatic Injury

A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable by time and place of occurrence and member of the body affected; it must be caused by a specific event or incident or series of events or incidents within a single day or work shift. Traumatic injuries also include damage to or destruction of prosthetic devices or appliances, including eyeglasses and hearing aids if they were damaged incidental to a personal injury requiring medical services. (Personal property claims can be made only under the Military Personnel and Civilian Employees' Claims Act, 31 USC 240.)

A. Notice of Injury: Form CA-1. When an employee sustains a traumatic injury in the performance of duty, he or she should give a written report on Form CA-1 to the supervisor as soon as possible but not later than 30 days from the date of injury. If the employee is incapacitated, this action may be taken by someone acting on his or her behalf, including a family member, union official, representative, or agency official. The form must contain the original signature of the person giving notice. The supervisor should:

(1) Review the front of the form for completeness and accuracy, and assist the employee in correcting any deficiencies found;

(2) Complete and sign the reverse of Form CA-1, including a telephone number in case OWCP personnel have questions about the injury. Also, insert the appropriate codes on both the front and back of the form. Codes should be included for occupation, type and source of injury, agency identification, and location of duty station by zip code (Appendix G of this publication describes the type and source of injury codes and their use).

(3) Sign and return to the employee the receipt attached to Form CA-1 and give a copy of the form to the employee if requested;

(4) Authorize medical care if needed in accordance with paragraph (b) below;

(5) Inform the employee of the right to elect continuation of regular pay (COP) (discussed in detail in Chapter 5), or annual or sick leave if time loss will occur;

(6) Advise the employee whether COP will be controverted, and if so, whether pay will be terminated. The basis for the action must be explained to the employee. (Controversion is discussed in Chapter 5-3; the reason for controverting a claim must always be shown on Form CA-1.)

(7) Advise the employee of his or her responsibility to submit *prima facie* medical evidence of disability within 10 working days or risk termination of COP (see Chapter. 5-8).

B. If the employee incurs medical expense or loses time from work beyond the date of injury, the supervisor should submit Form CA-1 to the district office with supporting information as soon as possible but no later than 10 working days after receipt of Form CA-1 from the employee. (Remember: the CA-1 should be filed through SMIS. https://www.smis.doi.gov)

If the employee is examined or treated at the agency's medical facilities or by medical providers under contract to the agency, and the examination or treatment occurs during working hours beyond the date of injury, the supervisor should add the words "first aid" to the upper right hand corner of the agency's portion of the CA-1 and submit it to OWCP. "First aid" injuries include those requiring two or more visits to the medical facility for examination or treatment during non-duty hours beyond the date of injury; as long as no leave or continuation of pay is charged and no medical expense is incurred.

If no medical expense will be incurred and no time will be lost from work beyond the date of injury, the Form CA-1 should be retained in the Employee Medical Folder (EMF) instead of sending it to OWCP.

C. Medical Treatment-Form CA-16. If an employee requires medical treatment because of the injury, the supervisor should promptly complete

the front of Form CA-16 within four hours of the request whenever possible. If the supervisor doubts whether the employee's condition is related to the employment, he or she should so indicate on the form. In an emergency, where there is no time to complete a Form CA-16, the supervisor may authorize medical treatment by telephone and then forward the completed form to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is usually not permitted under other circumstance.

(1) Delayed Report of Injury. If an employee has reported an injury several days after the fact, or did not request medical treatment within 24 hours of the injury, the supervisor may still authorize medical care using Form CA-16. DOI personnel are encouraged to use discretion in issuing authorizations for medical care under such circumstances, but employees should not be penalized for short delays in reporting injuries. The supervisor may, however, refuse to issue a CA-16 if more than a week has passed since the injury on the basis that the need for immediate treatment would normally have become apparent in that period of time. An employee may not use Form CA-16 to authorize his or her own medical treatment.

(2) Choice of Physician. The employee is entitled to select the physician or facility which is to provide treatment. The provider must meet the definition of "physician" under the FECA and must not have been excluded from payment under the program (refer to Chapter 6 for guidance in authorizing providers). An agency may make its own facilities available for examination and treatment of injured employees, but may not mandate use of its facilities to the exclusion of the employee's choice. Physicians employed by or under contract to the agency may examine the employee at the agency's facility in accordance with OPM regulations, but the employee's choice of physician must be honored, and treatment by the employee's physician must not be delayed.

(3) Obtaining Treatment. Along with Form CA-16, the supervisor should give the employee Form OWCP-1500, which is used for billing (this form is discussed in Chapter 6). The physician should complete the reverse of Form CA-16 and the OWCP-1500 and forward them to OWCP; the supervisor may ask the physician for a copy of the report as well. The employee may be furnished transportation and/or reimbursed for travel and incidental expenses. OWCP generally considers 25 miles from the agency or the employee's

home a reasonable distance to travel for medical care unless appropriate care is not available within that radius.

(4) Further Referral. The original treating physician may wish to refer the employee for specialized treatment or for further testing. He or she may do so on the basis of the Form CA-16 already issued; it is not necessary to issue additional authorizations for treatment. Both the original physician and any physician to whom the employee is referred are guaranteed payment for 60 days from the date of issue of Form CA-16 unless OWCP terminates this authority at an earlier date. Treatment may continue at OWCP expense if the claim is approved. Should the employee wish to change physicians after the initial choice, he or she must contact OWCP in writing for approval and include the reasons for requesting the change.

D. Medical Reports: Forms CA-20, CA-20a, and CA-17. In cases sent to OWCP, a medical report from the attending physician is required. This report may be made on Form CA-16 or on Forms CA-20 or CA-20a, which are attached to compensation claim forms. It may also be made by narrative report on the physician's letterhead stationery, or in the form of an emergency room summary. In all instances, however, the physician's original signature must appear on the report. The supervisor should supply medical report forms to the employee for completion by the physician as often as needed. These reports should be submitted in original form to OWCP.

DOI personnel should use Form CA-17, Duty Status Report, to obtain interim medical reports concerning the employee's fitness for duty; it may be issued initially with Form CA-16. The supervisor should complete the agency's portion of the form by describing the physical requirements of the employee's job and noting the availability of any light duty. The physician should forward the original Form CA-17 to the agency and a copy to the district office. The supervisor may send Form CA-17 to the physician at reasonable intervals (but not more often than once a week) to monitor the employee's medical status and ability to return to light or full duty. (Offers of light duty during the COP period are discussed in Chapter 5.)

E. Wage Loss/Permanent Impairment: Form CA-7.
If disability is anticipated at the time of injury, the employee may elect to use leave or COP (which is discussed in Chapter 5) on Form CA-1. An employee who cannot return to work when COP terminates, or who is not entitled to receive COP, may claim compensation for wage loss on Form

CA-7. In controverted cases where pay is terminated, Form CA-7 should be submitted with Form CA-1.

(1) When to File. If disability is expected to continue beyond the period of entitlement to COP, the employee may claim compensation or use leave to cover his or her absence from work. If it is not clear whether the employee will remain disabled after the 45 days of COP are used, claim for compensation should be initiated. Employees who have filed claims should be carried in LWOP status. If an employee returns to work after Form CA-7 has been filed, however, the supervisor should notify OWCP by telephone to avoid overpayments, and later provide written confirmation of return to duty.

(2) Completion. If compensation is to be claimed, the supervisor should give Form CA-7 to the employee on the 30th day of COP with instructions to complete the front and return the form to the agency within one week. (If the employee has not returned it by the 40th day of COP, the supervisor should contact him or her by telephone and request that it be submitted as soon as possible). The supervisor should also indicate the address of the district office in the box on the reverse of the Form CA-20 which is attached to the claim form.

When the form is returned, the supervisor should complete the reverse of the form, including the name and the telephone number of an agency official with direct knowledge of the claim. The employee should arrange to provide medical evidence to support the period of disability claimed; this evidence may be submitted with the Form CA-7 or sent to OWCP separately.

(3) Submission. After completing the form, the supervisor should submit it to OWCP along with any new medical evidence in the agency's possession. OWCP will use the pay data supplied by agency personnel to determine the rate at which compensation is to be paid. (Submission should not be delayed for computation of shift differential, Sunday or holiday pay, or other incremental pay; these elements, which are discussed in Chapter 8, may be computed and submitted separately). The dates of compensation claimed should represent the period of disability supported by the medical evidence or the interval until the employee's next medical appointment.

(4) Leave Repurchase. An employee who uses sick or annual leave to avoid possible interruption of income may repurchase that leave, subject to agency concurrence, if the claim is approved. Form CA-7 may be used for this purpose as well. The employee and supervisor should supply the factual and medical evidence described above, and the supervisor should also provide a detailed breakdown of leave used, showing the number of hours charged for each day claimed and whether sick or annual leave was used.

(The relationship between COP use and leave use is discussed in Chapter 5-2.)

(5) Lost Wages for Medical Treatment. An employee who has returned to work but continues to require medical treatment during work hours may claim compensation for lost wages while undergoing or traveling to and from the treatment. For a routine medical appointment, a maximum of four hours of compensation is usually allowed. Such a claim may be made on Form CA-7, and it should be accompanied by a statement from the supervisor showing the exact period of time and the total amount of wages lost due to the treatment, the rate of pay and the number of hours or days the employee would have worked if available.

Form CA-7 may also be used to claim continuing compensation for wage loss. During the period of disability, a new Form CA-7 should be submitted every two weeks absent other instructions from OWCP. Finally, Form CA-7 is used to claim schedule award for permanent impairment as a result of traumatic injury (entitlement to such awards is discussed in Chapter 7-1).

2-3. Occupational Disease

An occupational disease is defined as a condition produced in the work environment over a period longer than one work day or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment.

A. Notice of Occupational Disease-Form CA-2. The injured employee, or someone acting on his or her behalf, should give notice of occupational disease on Form CA-2. The supervisor should issue to the employee two copies of the appropriate checklist, Form CA-35a-h, for the disease claimed. (Specific checklists have been devised for various conditions in order to facilitate submission of evidence--see Appendix F.) The supervisor should also explain the need for detailed information to the employee and advise him or her to furnish supporting medical and factual information requested on the checklist. If possible, this information should accompany the form when it is submitted. Upon receiving Form CA-2, the supervisor should:

(1) Review the front of the form for completeness and accuracy, and assist the employee in correcting any deficiencies found;

(2) Complete and sign the reverse of Form CA-2, including a telephone number in case OWCP personnel have questions about the claim. Also, show the appropriate codes for occupation, type and source of injury, agency identification, and location of duty station by zip code. (Appendix B describes the type and source of injury codes and their use.)

(3) Sign and return to the employee the receipt attached to Form CA-2 and give a copy of the form to the employee if requested;

(4) Review the employee's portion of the form and provide comments on the employee's statement;

(5) Prepare a supporting statement to include exposure data, test results, copies of reports of previous medical examinations, and/or witness statements, depending on the nature of the case. The checklist may be used to coordinate compilation of material by agency personnel, including compensation specialists and safety and health officers;

(6) Advise the employee of the right to elect sick or annual leave or leave without pay, pending adjudication of the claim. The supervisor should submit completed Form CA-2 to the district office within 10 working days of receipt from the employee. It should not be held for receipt of supporting documentation. (Remember: the CA-2 should also be filed through SMIS. https://www.smis.doi.gov)

B. Medical Treatment: Form CA-16. Only rarely do employing agency personnel authorize medical care in occupational disease claims. The supervisor must contact OWCP before issuing a Form CA-16 in such a claim.

C. Wage Loss: Form CA-7. Form CA-7 is used to file an original claim for compensation because of pay loss resulting from an occupational disease. The claim should be filed within 10 days after pay stops or when the employee returns to work, whichever occurs first.

(1) Leave Repurchase. The employee may wish to use sick or annual leave pending adjudication of the claim. If so, the employee may initiate repurchase of this leave, subject to agency concurrence, using Form CA-7. The supervisor should certify the amount and kind of leave used for each day claimed, and the employee should arrange for submission of medical evidence supporting the period of repurchase requested.

(2) Lost Wages for Medical Treatment. An employee who has returned to work but continues to require medical treatment during work hours may claim compensation for lost wages while undergoing or traveling to and from the treatment. For a routine medical appointment, a maximum of four hours of compensation is usually allowed. Such a claim may be made on Form CA-7, and it

should be accompanied by a statement from the supervisor showing the exact period of time and the total amount of wages lost due to the treatment, the rate of pay and the number of hours or days the employee would have worked if available. Form CA-7 may also be used to claim continuing compensation for wage loss. During the period of disability, a new Form CA-7 should be submitted every two weeks absent other instructions from OWCP. Finally, Form CA-7 is used to claim schedule award for permanent impairment as a result of traumatic injury (entitlement to such awards is discussed in Chapter 7-1).

2-4. Recurrences

A recurrence is defined as a spontaneous return or increase of disability due to a previous injury or occupational disease without intervening cause, or a return or increase of disability due to a consequential injury (defined in Chapter 3-5). A recurrence differs from a new injury in that with a recurrence, no event other than the previous injury accounts for the disability.

Follow-up medical care for an injury or disease which causes time loss is considered part of the original injury rather than a recurrence unless the employee was previously released from treatment.

A. Claim for Recurrence: Form CA-2a. If a recurrence develops, the employee and supervisor should complete Form CA-2a and submit it to OWCP. If the employee was entitled to use COP and the 45 calendar days of COP have not been exhausted, he or she may elect to use the remaining days if 90 days have not elapsed since first return to duty (see Chapter 5-7 for detailed information). Otherwise, the employee may elect to use sick or annual leave pending adjudication of the claim for recurrence. The employee should arrange for submission of the factual and medical evidence described in the instructions attached to the form, paying particular attention to the need for "bridging" information which describes his or her condition and job duties between the original injury and the recurrence.

B. Medical Treatment: Form CA-16. Ordinarily, no medical treatment is authorized at OWCP expense until a claim for recurrence is accepted. At its discretion the district office may, however, authorize an emergency medical examination without Form CA-2a. The supervisor, at his or her discretion, may issue Form CA-16 to authorize examination or treatment for a recurrence of disability if it resulted from an injury previously recognized as compensable by the OWCP. The supervisor may not authorize examination or treatment when OWCP has disallowed the original claim or when more than six months have elapsed since the employee last returned to work.

C. Claim for Wage Loss: Form CA-7 is used to file a claim for continuing compensation due to recurrence. During the period of disability, a new Form Ca-7 should be submitted every two weeks absent other instructions from OWCP.

2-5. Death

When an employee dies because of an injury incurred while in performance of duty; the supervisor should immediately notify the district office by telephone or facsimile message. The supervisor should also contact any survivors, provide them with claim forms, and assist them in preparing the claim as much as possible. The forms should be submitted even if a disability claim had previously been filed and benefits were paid. Continuation of benefits is not automatic, as it must be shown that the death resulted from the same condition for which the disability claim was accepted.

A. Claims for Death Benefits: Forms CA-5 and CA-5b. The survivors of a deceased employee should use Form CA-5 or CA-5b to submit claims for death benefits. The survivor should complete the front of the appropriate form, while the attending physician should complete the medical report on the reverse and forward it to OWCP. The submission should include a copy of the death certificate which has been certified by the issuing authority. It should also include a certified marriage certificate if a spouse is making claim, and a copy of any divorce or annulment decree if the decedent or spouse was formerly married. The submission should include certified copies of birth certificates of any children for whom claim is made.

B. Agency Notice: Form CA-6. The supervisor uses this form to report the work-related death of an employee.

CHAPTER 3. CONDITIONS OF COVERAGE

Each claim for compensation must meet certain requirements before it can be accepted. This is true whether the claim is for traumatic injury, occupational disease, or death. While the requirements are examined somewhat differently according to the type of claim, they are always considered in the same order. This chapter will describe these requirements as well as the three statutory prohibitions to payment of compensation. It will also describe the kind of information which should be submitted by the supervisor and employee for each issue.

3-1. Time

All cases must first satisfy the statutory time requirements of the FECA.

A. Provisions of the Law. For injuries and deaths on or after September 7, 1974, the law provides that a claim for compensation must be filed within three years of the injury or death. Even if claim is not filed within three years, however, compensation may still be allowed if written notice of injury was given in 30 days or the immediate superior had actual knowledge of the injury or death within 30 days after occurrence. This knowledge may consist of written records or verbal notification; an entry into an employee's medical record may also satisfy this requirement if it is sufficient to place the agency on notice of a possible work-related injury or illness.

The law also provides that the filing of a disability claim because of injury will satisfy the time requirements for a death claim based on the same injury. OWCP may excuse failure to comply with the three year time requirement because of exceptional circumstances (for example, being held prisoner of war). For injuries occurring before September 7, 1974, different provisions apply with respect to timeliness. Contact the district office concerning any case in this category.

B. When Time Begins to Run. For traumatic injury, the statutory time limitation begins to run from the date of injury. For a latent condition, it begins to run when an injured employee who has a compensable disability becomes aware, or reasonably should have been aware, of a possible relationship between the condition and the employment. In situations where the exposure to

possibly injurious employment-related conditions continues after this knowledge, the time for filing begins to run on the date of the employee's last exposure to the implicated conditions. In death cases resulting from traumatic injury, time begins to run from the date of death.

Where death is due to disease, time begins to run when the beneficiary is aware, or reasonably should have been aware, of causal relationship between the death and the factors of employment. For a minor, the time limitations do not begin to run until the person reaches the age of 21 or has a legal representative. For a person who is mentally incompetent, the time limitations do not begin to run until the person has a legal representative.

C. Written Notice. Form CA-1 or CA-2 constitutes notice of injury. A claim for compensation (Form CA-7 in disability cases, CA-5 or CA-5b in death cases) may also constitute notice of injury. Moreover, OWCP will accept as a notice of injury or death any written statement which is signed by the person claiming benefits or someone acting on his or her behalf and which states the name of the employee; the name and address of the person claiming benefits; the time and location of the injury or death; and the cause and nature of the injury or death.

D. Actual Knowledge. An agency official may acquire actual knowledge through firsthand observation of the incident, from another employee, or from medical personnel at the agency's medical facility. This knowledge must place the employing establishment reasonably on notice of an on-the-job injury or death. An entry into the employee's medical records may be considered actual knowledge, as may the results of tests conducted by agency personnel in connection with known occupational hazards. The date on which the agency or OWCP receives written notice will be considered the date of filing. Information addressing the issue of actual knowledge is needed only when the agency did not receive written notice within three years.

3-2. Civil employee

If the claim is timely filed, it must be determined whether the injured or deceased individual was an "employee" within the meaning of the law. This is always the second requirement considered.

A. Provisions of the Law. The FECA covers all civilian federal employees except for non-appropriated fund employees. In addition, special legislation provides coverage to Peace Corps and VISTA volunteers; federal petit or grand jurors; volunteer members of the Civil Air Patrol;

ROTC cadets; Job Corps and Youth Conservation Corps enrollees; and non-federal law enforcement officers under certain circumstances involving crimes against the United States.

B. Other Considerations. Temporary employees are covered on the same basis as permanent employees. Contract employees, volunteers, and loaned employees are covered under some circumstances; such determinations must be made on a case by case basis once a claim is filed. Federal employees who are not citizens or residents of the U.S. or Canada are covered subject to certain special provisions governing their pay rates and computation of compensation payments.

3-3. Fact of Injury

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

A. Occurrence of Event. Whether the employee actually experienced the accident, event, or employment factor which is alleged to have occurred, this is resolved on the basis of factual evidence, including statements from the employee, the supervisor, and any witnesses. An injury need not be witnessed in order to be compensable. A supervisor who believes, however, that the employee's testimony is contrary to the facts should supply pertinent information to support this belief.

B. Medical Condition. Whether the accident or employment factor resulted in an injury or disease; this is determined on the basis of the attending physician's statement that a medical condition is present which may be related to the incident. Simple exposure, for instance to a contagious condition or dusty environment, does not constitute an injury.

3-4. Performance of Duty

If the first three criteria have been accepted, it must be determined whether the employee was in the performance of duty when the injury occurred.

A. Agency Premises. An employee who is injured on agency premises during working hours has the protection of the FECA unless engaged in an activity which removes him or her from the scope of employment. Coverage includes injuries which occur while the employee was performing assigned duties or engaging in an activity which was reasonably associated with the employment. Such activities include use of facilities for the employee's comfort, health, and convenience as well as eating meals and snacks provided on the premises. The premises include areas immediately outside the building, such as steps or sidewalks, if these are federally owned or maintained. The supervisor should document an

injury occurring in such an area by submitting a diagram showing where it happened.

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

(2) Representational Functions. Injuries to employees performing representational functions entitling them to official time are covered. Injuries to employees engaged in the internal business of a labor organization, such as soliciting new members or collecting dues, are not covered. The supervisor should advise whether the employee was entitled to official time when injured.

(3) Parking Facilities. The agency's premise includes the parking facilities which it owns, controls, or manages. An employee will usually be covered if injured on such parking facilities. Information submitted by the supervisor should include a statement indicating whether it owns or leases the parking lot, and if the latter, the name and address of the owner (this information may be needed for purposes of developing the third-party aspect of the claim, which is described in Chapter 4-1). If the parking lot is not immediately adjacent to the building, the supervisor should also supply a diagram showing where the injury took place in relation to the parking lot and building.

(4) Agency Housing. An employee is covered if injured during the reasonable use of premises which he or she is required or expected to occupy, and which are furnished or made available by the agency. (Employees using such housing include firefighters and Job Corps enrollees.) Any claim for injury occurring under such circumstances should be accompanied by a full description of the living arrangements and the requirements and expectations surrounding their use.

B. Off-Premises Injuries. Coverage is extended to workers such as letter carriers, chauffeurs, and messengers who perform service away from the agency's premises. It is also extended to workers who are sent on errands or special missions and workers who perform services at home.

(1) To and From Work. Employees do not have the protection of the FECA when injured en route between work and home, except where the agency furnishes transportation to and from work, the employee is required to travel during a curfew or an emergency, or the employee is required to use his or her vehicle during the work day. Such claims should be accompanied by a description of the circumstances.

(2) Lunch Hour. Injuries which occur during lunch hour off the premises are not ordinarily covered unless the employee is in travel status or is performing regular duties off premises.

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

(4) Vehicular Accidents. Any claim involving a traffic accident should be accompanied by a copy of the police report, if any, and a diagram or map showing the location of the accident in relation to the places where official duty was last performed and next scheduled.

C. Other Factors. Some injuries occur under circumstances which are not governed, or not completely governed, by the premises rules. Injuries involving any of the circumstances indicated below must be determined on a case-by-case basis.

(1) Recreation. An employee is covered while engaged in formal recreation for which he or she is paid or is required to perform as a part of training or assigned duties. Also covered are employees engaged in informal recreation, such as jogging, while on the agency premises. Under other circumstances, the agency must explain what benefit it derived from the employee's participation, the extent to which the agency sponsored or directed the activity, and whether the employee's participation was mandatory or optional.

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

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

(4) Emergencies. Coverage is extended to employees who momentarily step outside the sphere of employment to assist in an emergency, such as to extinguish a fire or assist a person in imminent danger.

3-5 Causal Relationship

After the four factors described above have been considered, causal relationship between the condition claimed and the injury or disease sustained is examined. Unlike fact of injury, which is discussed in paragraph (3-3) above and which involves the determination that a medical condition is present, causal relationship involves establishment of a connection between the injury and the condition found. This factor is based entirely on medical evidence provided by physicians who have examined and treated the employee. Opinions of the employee,

supervisor or witness are not considered, nor are general medical information contained in published articles.

A. Kinds of Causal Relationship. An injury or disease may be related to employment factors in any one of four ways:

(1) Direct Causation. This term refers to situations where the injury or factors of employment result in the condition claimed through a natural and unbroken sequence.

(2) Aggravation. If a pre-existing condition is worsened, either temporarily or permanently, by a work-related injury, that condition is said to be aggravated.

(a) Temporary aggravation involves a limited period of medical treatment and/or disability, after which the employee returns to his or her previous physical status. Compensation is payable only for the period of aggravation established by the medical evidence, and not for any disability caused by the underlying disease. This is true even if the employee cannot return to the job held at time of injury because the pre-existing condition may be aggravated again. For example, if exposure to dust at work temporarily aggravates an employee's pre-existing allergy, compensation will be payable for the period of work-related disability but not for any subsequent period, even though further exposure in the work place may cause another aggravation.

(b) Permanent aggravation occurs when a condition will persist indefinitely due to the effects of the work-related injury or when a condition is materially worsened by a factor of employment such that it will not return to the pre-injury state.

(3) Acceleration. A work-related injury or disease may hasten the development of an underlying condition, and acceleration is said to occur when the ordinary course of the disease does not account for the speed with which a condition develops.

(4) Precipitation. This term refers to a latent condition which would not have manifested itself on this occasion but for the employment. For example, an employee's latent tuberculosis may be precipitated by work-related exposure.

B. Medical Evidence. The issue of causal relationship almost always requires reasoned medical opinion for resolution. This opinion must be obtained from a physician who has examined or treated the employee for the condition claimed. In any case where a pre-existing condition involving

the same part of the body is present, the physician must provide rationalized medical opinion which differentiates between the effects of the employment-related injury or disease and the pre-existing condition. Such evidence will permit the proper kind of acceptance (temporary vs. permanent aggravation, for instance).

To establish causal relationship, additional medical opinion may be requested of OWCP's District Medical Director/Adviser or from a specialist in the medical field pertinent to the injury or disease. In a claim for a psychiatric condition, a report from a psychiatrist or licensed clinical psychologist will be required to meet this criterion. In claims for occupational hearing loss and pulmonary disease, the OWCP will refer the employee for examination by an appropriate specialist after exposure to the hazardous substance or condition has been established. Chapter 6 may be consulted for further information concerning medical examinations.

C. Consequential and Intervening Injuries. Sometimes an injury occurring outside performance of duty may affect the compensability of a work-related injury.

(1) A consequential injury is a new injury which occurs as the result of a work-related injury; for example, it occurs because of weakness or impairment caused by a work-related injury. Included in this definition are injuries sustained while obtaining medical care for a work-related injury. Consequential injuries are compensable.

(2) An intervening injury is one which occurs outside the performance of duty to the same part of the body originally injured. The resulting condition will be considered related to the original injury unless the second injury alone is established as its cause.

3-6 Statutory Exclusions

Sometimes the circumstances of a case raise the issues of willful misconduct, intention to bring about the injury or death of oneself or another, or intoxication. If any of these factors is established as the cause of the injury or death, benefits must be denied. Interior or OWCP personnel must assert and prove these factors.

A. Willful Misconduct. The question of deliberate willful misconduct may arise when the employee violated a safety rule, disobeyed other orders of the employer, or violated a law. Because safety rules have been established for the protection of the worker rather than the employer, simple negligent disregard of such rules is not sufficient to deprive an employee or beneficiary of entitlement to compensation. Disobedience of such orders may destroy the right to compensation only if the disobedience is deliberate and intentional as distinguished from careless and heedless.

B. Intoxication. In any case involving intoxication (whether by alcohol or any other drug) the record must establish both the extent to which the employee was intoxicated at the time of the injury and the particular manner in which the intoxication caused the injury. It is not sufficient just to show that the employee was intoxicated; it must be shown that the intoxication proximately caused the injury. This requirement does not, however, provide agency personnel with any additional authority to test employees for drug use beyond that which may exist under other statutes or regulations.

C. Intention to Bring About Injury or Death to Oneself or Another. Where it appears that the employee brought about his or her own injury or death, or that of another, intention must be established. If the factual and medical evidence shows that the employee was not in full possession of his or her faculties, the injury may be compensable. Thus, suicide may be compensable if the injury and its consequences directly caused a mental disturbance or physical condition which produced a compulsion to commit suicide and prevented the employee from exercising sound discretion or judgment so as to control that compulsion.

CHAPTER 4. PROCESSING CLAIMS

This chapter describes general procedures and responsibilities for case handling once the proper forms and information have been filed with OWCP. It also describes the steps which agency personnel should take if it believes a claim to be questionable.

4-1. Administrative Matters

A. Initial Handling. The notice of traumatic injury, occupational disease or death should be filed with the district office with jurisdiction over the location of the employing agency. (After adjudication, the claim may be transferred to the district office with jurisdiction over the location of the employee's residence, if different.) When possible, the notice should be accompanied by supporting documents such as medical reports and statements from the employee, the supervisor, and witnesses. When the notice is received, OWCP will send the employee and the supervisor a postcard (Form CA-801) advising the claim number assigned to the case. Uncontroversial claims with medical bills totaling less than $1000, no claim for compensation benefits, and no potential third-party liability will be administratively closed after payment of any outstanding medical bills. Claims not meeting these criteria will be assigned to a Claims Examiner for formal adjudication, as will those which pass the $1000 threshold for medical bill payment.

The Claims Examiner will determine if information in addition to the initial submission is required to adjudicate the claim. If so, the information will be requested of the employee and/or the supervisor with a copy to all parties to the claim. While the requirements for accepting a claim are considered in the order shown in the previous chapter, OWCP will attempt to request information on all unresolved aspects of the claim simultaneously in the interests of efficient case handling.

B. Obtaining Information. Agencies and employees usually communicate with OWCP in writing. Most district offices have a contact office which can provide information on the status of a claim and answer general questions. When more detailed information is needed, the Claims Examiner responsible for the case file can often satisfy the inquiry. A supervisor with questions about common themes identified in a number of claims should contact the Assistant District Director or District Director for clarification of the procedure in question. Only inquiries which cannot be resolved in this manner should be referred to OWCP's National Office, and any such matter should be

referred through the agency's headquarters. Policy questions may also be referred to OWCP's National Office. Under the Privacy Act, the employee or representative is entitled to receive one copy of the case file from OWCP free of charge; additional copies will be sent at a cost of $.10 per page. It is not necessary to request the records under the Freedom of Information Act.

Ordinarily, a complete copy of the record is sent directly to the requestor; occasionally, if sensitive medical information is involved, the district office will choose to forward the medical reports to a physician of the employee's choice so that the contents may be properly interpreted to the employee. Sensitive medical information may be released to the employee's representative, with the proviso that it not be disclosed to the employee, without the attending physician's permission.

C. Conferencing. Telephone conferences conducted by a Senior Claims Examiner are often held in cases involving complicated adjudicatory and case management issues. Conferences may be used to address the agency's controversion; the occurrence of an injury as claimed; the occurrence of an injury in performance of duty; occupational disease cases involving voluminous factual evidence or complex determinations; overpayments; and return to work efforts. Conferences may also be held where the employee is not able to express him or herself well in writing.

A representative of the employing agency may be asked to participate in such a conference, either with the Senior Claims Examiner alone or together with other parties to the claim. After the conference, the Senior Claims Examiner completes a Memorandum of Conference which describes what each party said, then asks the participant to provide any comments on this document within 15 days. The Senior Claims Examiner then makes findings on the issue for resolution and issues a decision accordingly.

D. Representation. The FECA provides that an employee may be represented if he or she so desires, but it is not required. A representative need not be an attorney; a union representative or friend, for example, may act in this capacity. The employee must designate any representative in writing before OWCP will recognize him or her. The law contains no provision for OWCP to pay representatives' fees. It does require, however, that OWCP approve such fees prior to payment. OWCP does not honor

contingency fee agreements, and the employee should not pay any fee prior to approval by OWCP, unless the fee is paid into a true escrow account.

E. Third Party. When a party other than the employee or agency personnel appears to be responsible for an injury or death, the employee may be asked to seek damages from that party, which may be an individual or product manufacturer. DOI personnel are encouraged to investigate the third party aspect of any claim and submit all information gathered to OWCP. The employee will be contacted with specific instructions concerning this aspect of the claim; he or she should not attempt to settle such a claim without first obtaining advice and approval from the Solicitor of Labor through OWCP.

While a claim is pending against the third party, OWCP will pay medical and compensation benefits to which the beneficiary is entitled. If a recovery is made, the beneficiary must first pay outstanding legal fees and costs. He or she is then entitled to retain 20 percent of the remaining amount, plus an amount equivalent to a reasonable attorney's fee in proportion to the sum which will be owed to OWCP. The latter amount generally includes the total medical and compensation payments made by OWCP up to the time of settlement. Any money remaining is retained by the beneficiary and credited against future claims for benefits. OWCP will resume payment of compensation benefits and medical bills only after the beneficiary has submitted claims which equal the amount of money remaining.

4-2. Burden of Proof

The employee is responsible for establishing the essential elements of the claim as described in Chapter 3. OWCP will assist the employee in meeting this responsibility, which is also termed burden of proof, by requesting evidence needed to fulfill the requirements of the claim if such information is not included with the original submission.

OWCP will attempt to obtain any pertinent medical evidence in the possession of another federal facility, including the employing agency, but this assistance does not relieve the employee of his or her burden of proof. Agencies are required by law to provide medical and factual evidence requested by OWCP in order to adjudicate a claim. Agencies and employees alike are always entitled to present information not specifically requested by OWCP.

When information is not submitted in a timely manner, delays in adjudicating cases and paying claims often result. To minimize such delays, OWCP will ask the employee and supervisor to submit the required evidence within a specific period, usually 30 days from the date of the request. A copy of any request to the supervisor for information will be sent to the employee, and vice versa. Following is a description of the procedures which OWCP uses with respect to requests for information from agencies.

A. Traumatic Injury Cases (Including Recurrence and Death).

(1) The factual evidence required from an employer in a traumatic case will often concern the circumstances surrounding the injury. By anticipating the information which OWCP will need, as described in the preceding chapter, agency personnel will often be able to avoid handling correspondence which would otherwise be generated. Each submission of forms should contain a clear description of how the injury occurred, including the time and place, whether it happened during working hours, the presence of witnesses, etc.

If this information is not included in the original submission, OWCP will request it. If a second request for such information is needed, OWCP will advise that absent a response the case will be processed on the basis of the evidence submitted by the employee as follows:

(a) If the employee's statement is sufficiently detailed and/or credible, OWCP will accepted the statement and adjudicate the claim accordingly.

(b) If the employee's statement is not sufficient and/or credible, the claim will be denied for the reason that one or more of the five basic elements required to approve a claim has not been established.

(2) Medical evidence in possession of the agency may also be requested.

(a) In an unadjudicated claim, the supervisor should submit copies of medical records pertaining to the injury and any relevant pre-existing condition at the time of initial submission to OWCP. This evidence will be requested of the agency if it is not sent with the original submission.

(b) In an accepted case, if the employee receives continuing care from an agency physician (or its contract provider), the supervisor should include supporting medical evidence for disability with claims submitted. Otherwise, the agency will be asked to submit the relevant medical evidence if the file does not support disability for the claimed period. If

the file contains prima facie medical evidence of disability for the period claimed but additional support is needed, OWCP will authorize payment for a reasonable period and request the evidence from the employer. If another claim is received and the previously requested evidence has not been submitted, OWCP will again authorize payment of compensation for a reasonable period and refer the employee to a medical specialist for examination.

(3) Payment information required will usually involve the employee's salary or the days of LWOP claimed or leave used during the period involved. Agencies can speed the payment process by advising OWCP of any elements of the pay rate which should be included, such as night and Sunday differential, and whether the employee has received these increments regularly (in which case the biweekly amount should be indicated) or sporadically (in which case the employee's entire earnings in the relevant pay category for the year preceding the injury should be provided).

Where the pay rate is in question, OWCP will begin paying compensation using the lower salary and request clarification from the supervisor. If a second request is necessary, the employee will be advised that documentation is necessary to support the higher pay rate and asked to submit any documentation in his or her possession. If the agency fails to reply and the employee submits adequate documentation (e.g., pay stubs), OWCP will adjust compensation. Until sufficient documentation is received from either the supervisor or the employee, compensation will be paid at the lower rate.

Where the days and hours of LWOP or leave status during a claimed period are in question, OWCP will request clarification from the supervisor. Any follow-up request needed will also advise the employee of the need for documentation and invite him or her to submit a detailed account for the period in question. If the employee provides such an account, OWCP will send a copy to the supervisor for review and advise that unless OWCP is notified of any inaccuracies in a timely manner, the employee's accounting will be used to compute the payment.

B. Occupational Disease Claims (Including Recurrence and Death).

(1) OWCP will require factual information from the employer according to the type and severity of the medical condition involved. (Simple occupational disease claims, for example a claim for poison ivy where the job duties involved exposure to the plant, and the medical evidence confirmed the diagnosis, require less

evidence to adjudicate.) The information specified in the instructions for completing Form CA-2 and on the evidence checklist appropriate to the disease in question should be forwarded with the initial submission. If sufficiently detailed descriptions of the circumstances surrounding development of the claimed condition are not received, OWCP will request whatever additional information is considered necessary for adjudication. If the information is not received, OWCP will process the case on the basis of the evidence submitted by the employee. As with traumatic injury cases, if that evidence is sufficient and/or credible, OWCP will accept the employee's statements and adjudicate the case accordingly. If the evidence is not sufficient and/or credible, OWCP will deny the case because one or more of the five basic elements required to approve a case has not been established.

(2) Medical examination and treatment will generally not have been provided solely by an agency medical facility. An employee who has also been seen by a private physician must submit supporting medical evidence from that physician. If additional evidence from the agency is needed, the employee will be advised that OWCP is attempting to obtain it but that the burden of proof still rests upon the employee and that he or she should also try to obtain that evidence.

(3) As with traumatic injury cases, wage loss information needed from the agency will probably involve the employee's pay rate or the days on LWOP or leave during the period claimed, and the procedures described for obtaining such information in traumatic injury cases will apply. The extensive development of medical evidence during the initial adjudication process should provide sufficient information concerning the nature and extent of disability to permit adjudication of the wage loss claim. If not, OWCP will follow the procedures for developing medical evidence in a traumatic wage loss claim.

Once OWCP accepts a claim, the burden of proof shifts from the employee to the OWCP. To rescind the acceptance of a condition or to make a retroactive determination that an employee was not disabled for a period during which compensation was paid, OWCP must demonstrate not only that an error was made but that the weight of the evidence supports its new conclusion concerning the merits of the claim. In practice, this means that new evidence is always required to rescind an acceptance.

4-3. Questionable Claims

If the supervisor questions the validity of a claim, he or she should investigate the circumstances and report the results to OWCP. All such allegations must be supported by specific factual evidence before OWCP can consider them.

Situations which may prompt the supervisor to conduct such an investigation, and actions which the agency may take, are as follows:

A. Differing Versions. If the employee has given differing versions of the incident to different people, or several witnesses give differing accounts of the facts surrounding the injury, the supervisor should request a written statement from each person which details his or her knowledge of the situation.

B. Previous Injury. If the employee reported to work on the date of the claimed injury with the appearance of a pre-existing condition or injury, the agency should obtain statements detailing the relevant observations from witnesses.

C. Time Lags. If a lengthy period elapses between the alleged injury and the time it is reported, and the employee appears to be able to perform normal duties, a written statement detailing the situation should be composed.

D. Other Employment. If an employee who has claimed injury is reported to be working at another job, the supervisor should first ask him or her about the requirements of the other employment. Depending on the reply, the supervisor may wish to ask the employee for permission to contact the other employer for information concerning duties and periods of employment. OWCP will consider all information submitted and correspond further with the parties involved if necessary. Also, OWCP may investigate the claim on its own authority, whether or not the agency has conducted an investigation. The authority to determine any aspect of a claim rests with OWCP, however, and while the agency is entitled to an explanation of the basis of OWCP's action, it must accept the determination rendered.

4-4. Decisions and Notification

The employee will be notified by letter of the acceptance of his or her case if disability is expected to ensue or continue. The letter will state the condition for which the claim is accepted and advises how to claim compensation benefits and payment or reimbursement of medical bills. In cases involving potential long-term disability, OWCP will notify the employee of his or her obligation to seek work when disability is no longer total. The supervisor will receive a copy of this notification to the employee and will also be asked to submit a copy of the employee's job description and SF-171 in order to prepare for eventual reemployment (this process is described in Chapter 8).

During the life of a claim, decisions may be rendered on various issues. Employees are usually notified by letter

about such matters as approval or denial of surgical procedures and other forms of medical care, and payment of medical bills by OWCP. Appeal rights are not usually included in such determinations, but formal decisions may be issued on such matters if requested.

Any determination, whether affirmative or negative, which sets forth OWCP's findings with respect to the case and which includes a description of the employee's appeal rights is known as a formal decision. When a beneficiary is placed on the compensation rolls for schedule award, loss of wage-earning capacity, or death, he or she will receive a formal decision. Likewise, a formal decision is issued any time an adverse decision involving entitlement is reached, such as denial of an initial claim or denial of continuing benefits. Three avenues of appeal are provided for employees; the agency is not entitled to appeal. The employee may request only one form of appeal at a time.

A. Hearing. The employee is entitled to either an oral hearing before an office representative or a review of the written record (but not both), as long as written request is made within 30 days of the formal decision, and reconsideration has not already been requested. The employee may change his or her hearing request in writing within 30 days of OWCP's acknowledgement of the initial request.

The request should be sent to the Branch of Hearings and Review at the address included with the appeal rights; no special form is needed. If an oral hearing is requested, it will be held within 100 miles of the employee's home, and he or she may present written evidence or oral testimony in support of the claim. If a review of the written record is selected, the employee may not present oral testimony, but may submit written evidence or argument.

If an oral hearing is requested, OWCP will advise the agency of the date and time. The agency may send one representative(or more, where appropriate) to the hearing and/or request a copy of the transcript. The agency representative may not participate in the proceedings, however, unless specifically invited to do so by the employee or OWCP representative.

For either and oral hearing or a review of the written record, OWCP will allow the agency representative 20 days to submit comments and/or additional documents, which will be subject to review and comment by the employee within an additional 20 day period. After an oral hearing is held or the review of the written record is completed, OWCP will issue a formal decision, including a description of the employee's further appeal rights.

B. Reconsideration. The employee may ask OWCP to reconsider a formal decision made by the district office. The request should be addressed to the district office handling the claim; no special form is required, but the request should clearly state the ground on which it is based. It must also be accompanied by relevant evidence not previously submitted or arguments for error in fact or law in reaching the contested decision. A reconsideration must be requested within one year of the date the contested formal decision was issued.

For any request which meets these criteria, OWCP will provide the agency representative with a copy of the employee's request, and allow 20 days for submission of comments and/or documents, this will in turn be subject to employee review and comment within 20 days. Following OWCP reconsideration, a new formal decision, which includes a description of the employee's further appeal rights, will be issued.

C. Review by Employees' Compensation Appeals Board (ECAB). An employee may request review by the ECAB, which is the highest authority in federal workers' compensation claims. The employee should file for such review directly with the ECAB at the address included with the formal decision. The ECAB's review is based solely upon the case record at the time of the formal decision; new evidence is not considered.

Employees residing within the continental United States or Canada should file application for review within 90 days of the date of the decision. Employees residing elsewhere should file within 180 days of the date of the decision. For good cause shown the ECAB may excuse failure to timely file an application for review if it is filed within one year of the date of the decision.

CHAPTER 5. CONTINUATION OF PAY (COP)

This chapter describes the employee's entitlement to continuation of his or her regular pay for periods of disability or medical care which occur shortly after a traumatic injury.

5-1. Definition and Entitlement

The FECA provides that an employee's regular pay may be continued for up to 45 calendar days of wage loss due to disability and/or medical treatment following a traumatic injury. The intent of this provision is to eliminate interruption in the employee's income while the claim is being adjudicated. COP is not considered compensation and is therefore subject to income tax, retirement and other deductions. After entitlement to COP is exhausted, the employee may apply for compensation or use leave.

An employee is entitled to receive COP when he or she is absent from work due to disability or medical treatment or when he or she is reassigned by formal personnel action to a position with a lower rate of pay due to partial disability. Because informal assignment of light or restricted duties without a personnel action does not result in pay loss, time worked in such a position may not be charged to COP. An employee whose work schedule is changed, however, so that a loss of salary or premium pay (e.g., Sunday pay or night differential) results, is entitled to COP for such wage loss whether or not the change in schedule was accomplished by a formal personnel action.

Temporary employees are entitled to COP on the same basis as permanent employees. If a termination date has been set for an employee prior to the injury, however, COP need not be continued past the date of termination as long as Form SF-52 showing the date of termination has been completed. In this instance OWCP will pay compensation to a disabled worker after employment as ceased. Like any other employee, a temporary worker who first reports a traumatic injury after the employment is terminated is not entitled to COP.

5-2. Use of Leave Instead of COP

An employee may use annual or sick leave to cover all or part of an absence due to injury. If an employee elects to use leave, each full or partial day for which leave is taken will be counted against the 45 days of entitlement. Therefore, while an employee may use COP intermittently along with sick or annual leave, entitlement is not extended beyond 45 days of combined absences.

An election of sick or annual leave during the 45-day period is not irrevocable. If an employee who has elected leave for the period wishes to elect COP, the supervisor must make such a change on a prospective basis from the date of the employee's request. Where the employee wishes to have leave restored retroactively, the supervisor must honor the request, provided he or she receives prima facie medical evidence of injury-related disability for the period.

5-3. Controversion

Sometimes a supervisor objects to paying a claim for continuation of pay, either for one of the reasons provided by regulation or for some other reason. This action is called controversion. The supervisor may controvert a claim by completing the indicated portion of Form CA-1 and submitting detailed information in support of the controversion to OWCP. Even though a claim is controverted, the agency must continue the employee's regular pay unless at least one of the conditions set forth below applies:

A. The disability is a result of an occupational disease or illness;

B. The employee comes within the exclusions of 5 USC 8101 (1) (B) or (E) (which refer to persons serving without pay or nominal pay, and to persons appointed to the staff of a former President);

C. The employee is neither a citizen nor a resident of the United States, Canada, or the territory under the administration of the Panama Canal Commission (i.e., a foreign national employed outside the areas indicated);

D. The injury occurred off the employing agency's premises and the employee was not engaged in official "off-premises" duties;

E. The employee caused the injury by his or her willful misconduct, or intended to bring about his or her injury or death or that of another person, or the employee's intoxication was the proximate cause of the injury;

F. The injury was not reported on a form approved by OWCP (usually Form CA-1) within 30 days following the injury;

G. Work stoppage first occurred more than 90 days following the injury;

H. The employee initially reported the injury after employment was terminated;

I. The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, work study program, or other group covered by special legislation. The agency may not continue pay under any of the above circumstances.

The agency may dispute an employee's right to receive COP (and/or the validity of the claim as a whole) on other grounds, for instance on the basis that the employee was not performing assigned duty when the injury occurred, or that the condition claimed is not the result of a work related injury. Any such objection should be supported by objective evidence such as witness statements, pictures, accident investigations, or time

sheets. If the validity of a claim is disputed for reasons other than the nine conditions listed above, regular pay must be continued for up to 45 calendar days and may not be interrupted during the 45-day period unless one of the conditions in Chapter 5-6 or 5-8 is met.

5-4. Pay Rate for COP

An employee's regular pay is his or her average weekly earnings, including premium pay, night or shift differential, Sunday or holiday pay, and other extra pay, including pay authorized by the Fair Labor Standards Act for employees who receive annual premium pay for standby duty and who also earn and use leave on the basis of their entire tour of duty, including periods of standby duty. Overtime pay should not be included, however, except for administratively uncontrollable work covered under 5 U.S.C. 5545(c)(2).

A. Standard Number of Hours. For a full-time or part-time worker, either permanent or temporary, who works the same number of hours per week, the weekly pay rate equals the number of hours regularly worked each week times the hourly pay rate on the date of injury, excluding overtime.

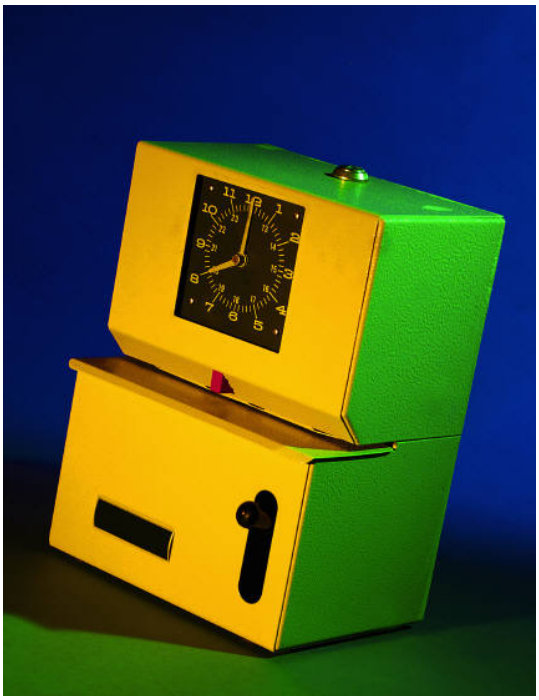
B. Non-standard Number of Hours. For a part-time worker, either permanent or temporary, who does not work the same number of hours per week, the weekly pay rate equals the average weekly earnings for the one-year period prior to the date of injury, excluding overtime.

C. Intermittent Work. For an intermittent or part time worker, either permanent or temporary, who does not work each week of the year (or the period of appointment), the weekly pay rate equals the average of the employee's weekly earnings during the one year before the injury. It is computed on the basis of the total earnings divided by the number of weeks worked (partial weeks worked are counted as whole weeks). The annual earnings used for this computation must not, however, be less than 150 times the average daily wage earned within one year before the date of injury (the daily wage is the hourly rate times eight).

D. Increments of Pay. Premium, night, or shift differential as well as Sunday, holiday, or other extra pay should be included, but overtime pay may not be considered.

E. Changes in Pay. Within-grade increases or promotions, demotions, terminations of temporary details, etc. which the employee would have received but for the injury are included in COP since this payment represents salary and not compensation. Moreover, an employee who does not exhaust his or her entitlement to COP at the time of injury and who is later entitled to use COP while employed at a higher paying job than the one held at the time of injury is entitled to receive COP at the higher rate of pay. Where the weekly COP rate is based on the employee's average weekly earnings over the one-year period prior to the date of injury, the COP rate should be changed by the same percentage as the change in hourly pay or salary.

F. Lost Elements of Pay. The effects of the injury sometimes result in loss of elements of pay such as night or Sunday differential (e.g., a night shift worker is reassigned to the day shift to perform prescribed light duty). In such situations COP should be granted for the lost elements of pay (e.g. the night differential). Each day for which COP is granted to cover lost elements of pay will count as one full day of COP toward the 45-day limit.



5-5. Computation

Unless the injury occurs before the beginning of the work day, time loss on the day of injury should be charged to administrative leave. The period to be charged to COP begins with the first day or shift of disability or medical treatment following the date of injury, provided that the absence began within 90 days after the injury. COP should be charged for weekends and holidays if the medical evidence shows the employee was disabled on the days in question; for example, if the physician indicates that disability will continue only through Saturday for an individual who has Saturday and Sunday off, COP will be charged only through Saturday.

If work stoppage occurs for only a portion of a day or shift, a full day of COP will be counted against the 45 calendar day entitlement, even though the employee is not entitled to COP for the entire day or shift. For example, if an employee who has returned to work must lose three hours in order to receive physical therapy for the effects of the injury, he or she is entitled to only three hours of COP even

though one full calendar day will be charged against the 45 day limit. If the employee is absent for all or part of the remaining work day, the time loss should be covered by leave, LWOP, AWOL, etc., as appropriate, since absence beyond the time needed to obtain the physical therapy cannot be charged to COP.

If the employee is only partially disabled following the injury, and continues to work several hours each work day, each day or partial day of absence from work is chargeable against the 45-day period.

5-6. Light Duty Assignments

When the physician's report indicates that the employee is no longer totally disabled, he or she 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; it should include a description of the duties and requirements of the offered position. If a personnel action is involved, the employee must be furnished with a copy of it prior to the effective date.

COP should be paid if the employee has been assigned light duty by formal personnel action and pay loss results (e. g., the employee is placed in a light duty position at lower pay). COP should also be paid if the light duty consists of work at regular duties for fewer than the usually scheduled number of hours. The dollar amount of COP will be the difference between the pay rates of the job held on date of injury and the light duty position. One full day of COP should be charged for each day of light duty, even though the employee is working a full shift.

If the employee refuses to accept the work offered, COP should be terminated as of the date of the employee's refusal or after five workdays from the date of the offer, whichever is earlier. OWCP will then determine entitlement based on the medical reports and the duties of the offered position and issue a formal decision concerning payment of COP. A discussion of the criteria used in making such determinations is contained in Chapter 8-4.

5-7. Recurrences

In many cases, an employee will return to work without using all 45 days of entitlement of COP. Should such an employee suffer a recurrence of disability, he or she may use COP if no more than 90 days have elapsed since the date of first return to work, including part-time work and light duty, following the first work stoppage. If the recurrence begins later than 90 days after the first return to work, the agency should not pay COP even though some days of entitlement remain unused. A period which begins before the 90 day deadline and continues beyond it may be charged to COP as long as the period of time is uninterrupted. If a third-

party credit has been established, the supervisor should contact OWCP before paying COP.

5-8. Terminating COP

COP should not be stopped except under the following circumstances:

A. Medical Evidence is Not Submitted within 10 Workdays. This period should be counted from the date the employee claims COP or the disability begins (or recurs), whichever is later. If the agency has not received *prima facie* medical evidence of injury-related disability within that period, COP may be discontinued. However, the agency may not wait 10 days to request such evidence, which is defined as medical evidence showing that the employee is disabled for the job held at the time of injury because of an employment injury. Pay may be continued without such evidence if the supervisor is satisfied that the employee sustained a disabling traumatic injury. For the purposes of this provision:

(1) The 10-workday period begins the workday after the employee claims COP or the disability begins (or recurs).

(2) A "workday" means the business day of the office or facility where the employee works or reports such that the medical evidence could be submitted by the employee to an authorized agency official.

B. The Employee is No Longer Disabled. The agency should terminate COP if it receives medical information from the attending physician stating that the employee is no longer disabled for regular work, if a partially disabled employee returns to full-time light duty with no pay loss, or if the employee refuses a suitable offer of light duty.

C. OWCP Notifies the Agency That Pay Should be Terminated.

D. The 45 Calendar Day Period Expires. An employee who is scheduled to be separated and reports a traumatic injury on or before the separation date should still be separated; he or she is entitled to COP up to the date of termination and to compensation thereafter.

5-9. Reporting COP-Form CA-1

A. Time Cards. Time loss for an employee who is receiving COP should be recorded as "COP" on the Time and Attendance Report. A diminishing record of the 45 day limitation is to be maintained in the "Remarks" block.

B. Completion of Forms CA-1. Sometimes, COP and return to duty information is shown on Form CA-1 when the injury is first reported. The agency may (but is not required to) provide a narrative letter and submit to OWCP. The letter should contain information on when entitlement to COP

ends, whether the employee returns to work, or if the disability ceases. In cases where COP is intermittent or for delayed disability, the agency should not include wages paid for light or limited duty of for parts of days actually worked

If the disability ends before the expiration of the 45 day period, the agency should terminate COP. An employee who is no longer disabled must return to work upon notification by the attending physician that he or she is able to perform full regular duty or suitable and available light duty. If the employee does not return to duty, an overpayment may result which is subject to collection by the agency.

C. Formal Decision. In all cases OWCP has the final authority to determine whether the agency's action in paying or terminating COP is correct. If entitlement is denied, OWCP will inform the employee and the supervisor by formal decision (Form CA-1050 is usually used for this purpose). Payment made may then be charged, at the employee's option, to sick or annual leave or be deemed an overpayment subject to collection by the agency.

CHAPTER 6. MEDICAL BENEFITS AND CARE

This chapter addresses the employee's entitlement to medical benefits under the FECA.

6-1. Entitlement

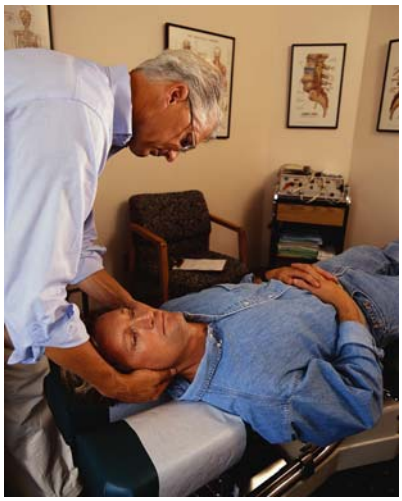
The FECA at 5 USC 8103 authorizes medical services needed to provide treatment or to counteract or minimize the effects of any condition which is causally related to factors of federal employment. No limit is imposed on the amount of medical expenses paid or on the length of time for which they are paid, as long as the charges represent the reasonable and customary fees for the services involved and the need for the treatment can be demonstrated.

Federal employees are entitled to all services, appliances, and supplies prescribed or recommended by qualified physicians who, in the opinion of OWCP, are likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. Medical care includes examination, treatment, and related services such as hospitalization, medications, appliances, supplies, and transportation incident to securing them. Preventive care may not be authorized, however.

6-2 Definition of Physician

The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors within the scope of their practice as defined by state law. Naturopaths, faith healers, and other practitioners of the healing arts are not recognized as physicians within the meaning of the law.

A. Chiropractors. Under the FECA, the services of chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. The term "subluxation" is defined as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae anatomically which must be demonstrable on any X-ray film to individuals trained in the reading of X-rays. Chiropractors may interpret their own X-rays, and if a subluxation is diagnosed the chiropractor's assessment of any disability caused by it will be accepted.



If a Form CA-16 is issued to a chiropractor for emergency care and the condition diagnosed is other than a subluxation, charges will be honored until OWCP terminates the authority of Form CA-16. In this situation the employee is entitled to select another attending physician, who will need

to submit a report substantiating the condition found and addressing any disability for work in order for the claim to be accepted.

B. Excluded Physicians. The term "qualified physician" does not include those whose licenses to practice medicine have been suspended or revoked by a state licensing or regulatory authority or who have been excluded from payment under the FECA (see 6-5, "Exclusion of Providers" below).

6.3 Choice of Physician

A. Initial Choice. An employee is entitled to initial selection of physician for treatment of an injury. He or she may choose any licensed physician in private practice who is not excluded, or he or she may choose to be treated at a government facility where one is available. Such facilities include medical officers and hospitals of the Army, Navy, Air Force, and Department of Veterans Affairs. Agency personnel may not interfere with the employee's right to choose a physician, nor may they require an employee who claims an injury to go to a physician who is employed by or under contract to the agency before going to the physician of the employee's choice. Agency personnel may contact the attending physician by telephone only to obtain additional information about or clarify the employee's duty status or medical progress.

B. Referral by Attending Physician. The attending physician may engage the services of other facilities which provide X-ray or laboratory services or of specialists whom the physician feels it necessary to consult. Charges for such services will usually be paid if they were requested by the attending physician.

C. Change of Physician. Except for referral by the attending physician, any change in treating physician after the initial choice must be authorized by OWCP. Otherwise, OWCP will not be liable for the expenses of treatment. The employee should request any such change in writing with an explanation of the reasons for the request. If a physician initially selected by an employee is later excluded from participation under the regulations, the employee should choose another physician. Otherwise, and upon notification by OWCP, he or she will be liable for payment of the bills from the excluded provider.

D. Transfer of Medical Care. The agency does not have authority to transfer medical care from one physician to another. If adequate medical care is not available locally or agency personnel believe that transfer of medical

care is advisable for other reasons, OWCP must be contacted for instructions.

6-4. Medical Treatment and Evaluation

A. Employee Requests. Some forms of medical treatment should be approved by OWCP in advance in order to guarantee payment. Among such services are:

(1) Non-emergency surgery; a second opinion examination may be included in the approval process. (OWCP may not require an employee to undergo surgery or any other invasive procedure, such as a myelogram);

(2) Private hospital room accommodations (only semi-private rooms will be authorized unless the employee's condition necessitates private accommodations;

(3) Hospital beds, traction apparatus, wheelchairs, and similar equipment;

(4) Orthopedic appliances and shoes;

(5) Nursing home care;

(6) Courses of physical therapy;

(7) Hearing aids and lip reading services;

(8) The services of hearing and seeing eye dogs; and

(9) Membership in health clubs.

The attending physician is responsible for requesting such services, and his or her reasons for believing that the services are needed should be included in the request. Prior authorization need not be obtained to purchase minor appliances such as a sacroiliac belt or an ankle strap, or for such items as crutches and canes if prescribed by the attending physician.

B. OWCP Requests. In addition to the attending physician, other medical personnel may be asked to evaluate an employee and/or file. Evaluations may be requested in connection with original or continuing entitlement to benefits, the percentage of the employee's permanent impairment or ability to return to full or light duty, or other issues. Physicians who may be asked to examine the employee and/or file are as follows:

(1) District Medical Director/Advisor (DMD/DMA). Each district office has one or more physicians on staff or under contract who respond to questions raised by OWCP staff. Issues include interpretation of medical issues posed by the treating physician and provision of the DMD/DMA's own opinion on medical questions. The DMD/DMA also considers requests for surgery and other modalities of treatment requiring OWCP approval. The

DMD/DMA does not, however, examine employees except where a claim for disfigurement of the face, head or neck is involved.

(2) Medical Specialist (Second Opinion Referral). Medical issues sometimes arise which cannot be resolved on the basis of opinions given by the attending physician and the DMD/DMA. Opinion will then be requested from a physician who specializes in the field of medicine pertinent to the issue. The appointment for examination may be made by OWCP, or the employee may be asked to make the appointment. In either case, OWCP will pay for the examination, reasonable travel expenses, and wage loss incurred in connection with it. The employee may bring a physician paid by him or her to the examination if desired. The compensation of an employee who fails to attend an OWCP-scheduled examination without good reason will be suspended until the employee reports for examination.

(3) Referee Medical Specialist. A conflict of medical opinion may be created when differing opinions of approximately equal weight appear in the file. Medical opinion from a referee specialist will then be arranged to resolve the conflict of opinion, which may concern the relationship of a condition to factors of employment, or the extent of disability, for example. The physician is chosen on the basis of rotation among the available specialists within a given geographical area who practice the pertinent area of medicine. OWCP will arrange the appointment and advise the employee of the arrangements. As with second opinion referral, OWCP will pay the cost of the examination, reasonable travel expenses, and the amount of lost wages. Here again, the compensation of an employee who fails to attend the examination without good reason will be suspended until the employee reports for examination.

C. Agency Requests. The FECA does not address the issue of medical examinations desired by the agency. Parts 339 and 353 of OPM's regulations grant broad authority to agencies to arrange for examination of any employee who files a compensation claim by a physician of the agency's choice, at the agency's expense. However, the purpose of such examinations is solely to determine if the individual is able to work in some capacity, thereby facilitating return to work.

Medical examinations may not be used to intimidate employees. While agencies must send the results of such examinations to OWCP and notify OWCP if the individual refuses to be examined, and the results of such examinations per se do not affect entitlement to compensation.

6-5. Exclusion of Providers

Certain providers may be excluded from participation in the federal employees' compensation program. The services of such providers may not be reimbursed by OWCP during the period of exclusion.

A. Fraud. Providers who have been convicted under a criminal statute for fraudulent activities in connection with a federal or state program which makes payments to providers for medical services are automatically excluded from participation in the FECA program. This means that OWCP will not honor their bills for services. Providers, who are excluded or suspended from similar federal or state programs, including Medicare, are also automatically excluded from participation in the FECA program.

B. Other Grounds. OWCP will initiate exclusion procedures upon receipt of information that a provider has knowingly made a false statement or misrepresented a fact in connection with a claim for reimbursement or request for payment; charged more than the provider's customary fee for similar services without good cause; failed to reimburse an employee who has paid a bill for treatment which was also paid by OWCP; repeatedly failed to submit full and accurate medical reports or failed to respond to requests for medical information; or furnished treatment substantially beyond the employee's needs, or which fails to meet professionally recognized standards.

C. Due Process. The regulations appearing at 20 CFR 10.450-457 include due process at every step to protect the rights of providers. These rights include administrative review of decisions and consideration of reinstatement after a period of exclusion if reasonable assurances exist that the action which led to the exclusion will not be repeated. Providers reinstated to participation in Medicare by the Health Care Financing Administration (HCFA) are automatically reinstated by OWCP.

D. Notification. OWCP will periodically distribute to agencies the names and addresses of excluded medical providers along with those who have been reinstated. Before authorizing medical services on Form CA-16, the supervisor should ensure that the medical provider selected by the employee is not among those excluded. An excluded physician may be reimbursed only for services rendered in a medical emergency. Designated agency officials should report instances of fraud or abuse coming to their attention to the district office.

E. Medical Charges. On receipt of a bill from an excluded provider, OWCP will determine whether either the agency or OWCP notified the employee that the provider was excluded from the program. If not, OWCP will honor the bill and advise both the provider and the employee that further treatment may not be paid in accordance with the regulations. An

employee whose initially chosen attending physician is excluded will be given the opportunity to choose a new physician.

6-6. Payment of Bills

Medical support is required to substantiate that services for which payment or reimbursement is requested were required for the accepted, work related injury. Documentation usually takes the form of a report or clinical notes from the physician. Hospital bills should be supported by a copy of the discharge summary.

A. Forms. Most providers must submit their bills on the American Medical Association (AMA) Standard Health Insurance Claim Form (HCFA-1500). A version of the form which includes instructions for submitting bills to OWCP carries the form number OWCP-1500. In some states the local version of the form may not be designated "HCFA-1500" or may differ from the standard AMA form in other ways. Such local variations are acceptable if they are otherwise complete.

The following providers are required to use Form HCFA-1500 to submit bills: physicians; nursing services; laboratories and X-ray facilities; chiropractors; therapists; and suppliers of medical equipment and goods. Dentists are encouraged to the HCFA-1500; they may use standard AMA form instead.

Pharmacies must use the Universal Claim Form. Hospitals must use Form UB-92, and nursing homes are encouraged to use this form as well. Bills rendered by ambulance services may be submitted on billhead, as may bills from foreign providers. Veterans Administration (VA) facilities may submit bills using Form VA-10-9014.

B. Requirements. To be accepted for payment, the bill must include the following information:

(1) Employee's name;
(2) Provider's name and address;
(3) Diagnosis;
(4) Itemized list of services, with charges; and
(5) Tax identification number (the provider's Employer Identification Number or Social Security Number).

C. Itemization. All bills must be sufficiently itemized to allow for evaluation of the charges. The Current Procedural Terminology (CPT) code for each medical, surgical, X-ray or laboratory service should be shown on the HCFA-1500, and bills should show the dates when the services or supplies were furnished. Individual dates are not necessary if the bill is for

repetitive charges over a period of time. In such cases the billing should show the beginning and ending dates of service, and the number of units of service.

D. Time Limitation on the Payment of Bills. No bill will be paid unless it is submitted to OWCP on or before December 31st of the year following the calendar year in which the expense was incurred or the claim (or specific condition, as appropriate) was first accepted as compensable by OWCP, whichever is later. This provision applies to any bill for which the later of the two dates falls on or after January 1, 1987.

E. Disallowance of Charges. Unless the amount involved is minor, OWCP will advise the payee fully of any adjustments to the bill by letter which explains the amount of the deletion or reduction, the particular charge affected, the reasons for the action, and the amount for which the bill is being approved. If a bill is reduced because the charges exceed the amount allowed by the OWCP fee schedule, a separate notice will be provided.

F. Reimbursement. An employee who has paid a provider may request reimbursement by submitting either receipted bills from the provider or a completed HCFA-1500 signed by the provider. Hospital bills must be stamped paid or otherwise certified to indicate that payment was made. Cash sales receipts that bear imprints of mechanical cash registers may be accepted if the nature of sale is identified. Photocopies of cancelled checks may be accepted in lieu of receipts but must be accompanied by itemized bills or other evidence of the charge for which payment was made. Prescription receipts must include the name of the drug and the date the prescription was filled.

G. Insurance Companies. The employee should advise medical providers to submit bills for services to OWCP. In some cases, however, bills are submitted to the employee's health insurance carrier. The carrier may request reimbursement for such charges by submitting a completed HCFA-1500 or similar OWCP-approved form. The form should list procedures and charges for each provider, and copies of paid bills and cancelled checks should be attached. It should also include the carrier's Tax Identification Number.

H. Transportation Expenses. When transportation to obtain medical care is not furnished by the government, the employee may be reimbursed for travel expenses. Travel should be undertaken by the shortest route and by public conveyance such as bus or subway unless the employee's medical condition requires the use of a taxicab or specially equipped vehicle. An employee who uses his or her automobile will be reimbursed at the standard mileage rate for government travel.

Standard Form 1012 should be used to claim reimbursement for travel expenses. All items will be reimbursed on the basis of actual expense; a per diem allowance is not payable. Wages and travel expenses of an attendant to accompany the employee may be approved if his or her condition is such that travel cannot be accomplished otherwise. Authorization for this expense should be obtained in advance of the travel if possible.

I. Incorrect Payments. An employee, who receives a reimbursement for medical expense which he or she knows to be incorrect, either partially or totally, should return the check to OWCP immediately. If an overpayment occurs, OWCP will determine whether the beneficiary is with fault in creation of the overpayment. Only if a beneficiary is determined to be without fault may waiver of the overpayment be considered.

CHAPTER 7. COMPENSATION BENEFITS

This chapter describes the various forms of compensation benefits which are available to injured employees and survivors in death claims. It also includes a section on computation of compensation benefits.

7-1. Disability Benefits

An employee who suffers employment-related disability may be eligible for one or more types of wage loss compensation. Such benefits are classified according to the nature and extent of disability incurred.

A. Temporary Total Disability. Compensation based on loss of wages is payable after the end of continuation of pay where entitlement exists (see Chapter 5) or from the beginning of pay loss. An employee without dependents is entitled to compensation at the rate of 66% of his or her salary. With dependents, he or she is entitled to 75% of the salary.

(1) Dependents. The following are considered dependents for compensation purposes:

(a) A wife or husband residing with the employee or receiving regular support payments from him/her, either court-ordered or otherwise;

(b) An unmarried child who lives with the employee or who receives regular contributions of support from him or her, and who is under the age of 18, or over the age of 18 and incapable of self-support due to physical or mental disability;

(c) A student between 18 and 23 years of age who has not completed four years of postsecondary education and who is regularly pursuing a full time course of study.

(d) A parent who is wholly dependent upon and supported by the employee.

(2) Waiting Days. A three-day waiting period, for which no compensation is payable, applies except in cases where disability extends more than 14 days or permanent disability results. In these cases compensation will be paid for the three days.

OWCP will notify an employee who receives long-term disability payments of the amount of compensation to be paid. Compensation payments for total disability may continue as long as the medical evidence substantiates total disability. Only rarely is an employee declared permanently and totally disabled; benefits provided to such an employee are the same as those provided for temporary total disability.

B. Schedule Awards. Compensation is provided for specified periods of time for the permanent loss, or loss of use, of certain parts and functions of the

body. Partial loss or loss of use of these parts and functions is compensated on a proportional basis.

(1) Compensation Schedule. Table 1 which shows the number of weeks payable for each schedule member if the loss or loss of use of the function or part of the body is total:

Table 1: Weeks Payable for Loss of Body Part

Member	No. of Weeks	Member	No. of Weeks
Arm	312	Loss of hearing—monaural	52
Leg	288	Binaural	200
Hand	244	Breast	52
Foot	205	Kidney	156
Eye	160	Larynx	160
Thumb	75	Lung	156
First finger	46	Penis	205
Great toe	38	Testicle	52
Second finger	30	Tongue	160
Third finger	25	Ovary (including Fallopian tube)	52
Toe, other than great toe	16	Uterus/cervix	205
Fourth finger	15	Vulva/vagina	205

Compensation for loss of binocular vision or for loss of 80% or more of the vision of an eye is the same as for loss of the eye. The degree of loss of vision or hearing for a schedule award is determined without regard to correction; that is, improvements obtainable with use of eyeglasses and hearing aids are not considered in establishing the percentage of impairment. The law contains no provision for payment of a schedule award on account of permanent impairment to the back, heart or brain.

(2) Medical Evidence Required. Before payment of a schedule award can be considered, the condition of the affected part of the body must reach maximum improvement. This determination involves a medical judgment that the condition has permanently stabilized. In most cases the percentage of impairment is determined in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, and the evaluation on which the award is based must conform to the guidelines set forth in that publication.

(3) Claim and Payment. If a claim for wage loss has not previously been submitted, Form CA-7 may be used to initiate a claim for schedule award. Otherwise, consideration may be requested by narrative letter. Compensation for schedule awards is computed by multiplying the indicated number of weeks times 66 percent (without dependents) or 75 percent (with dependents) of the pay rate (see paragraph (1) above for more information concerning dependents).

(4) Decision. When a schedule award is issued, the employee and agency will be notified of the length of the award (in number of weeks or days), the starting date of the award (the date of maximum medical improvement), the pay rate on which benefits are computed, and the compensation rate. The decision will include a description of the employee's appeal rights should there be disagreement with any element of the decision.

Schedule awards can be paid even if the employee returns to work. Employees may not, however, receive wage loss compensation and schedule awards benefits concurrently for the same injury. If an employee sustains a period of temporary total disability during the course of the award, it may be interrupted to pay the period of disability; the schedule award will resume afterwards. If an employee dies during the course of a schedule award from causes unrelated to the compensable injury, his or her dependents are entitled to the balance of the award at the rate of 66 percent.

C. Loss of Wage-Earning Capacity. When the medical evidence shows that the employee is no longer totally disabled, OWCP will take steps to effect reemployment of the employee, either with the original agency or with another employer (this process is described in Chapter 8). If the employee is reemployed at a job paying less than the original position, or if it is otherwise determined that he or she can perform the duties of a specific job that is deemed suitable, medically and otherwise, compensation will be payable based on this loss of wage-earning capacity.

(1) Payment. The FECA provides that employees who are partially disabled by an illness or injury causally related to federal employment shall be compensated at a rate equal to 66% (without dependents) or 75% (with dependents) of the wage loss incurred as a result of the disability (see paragraph (1) above concerning dependents). Benefits are paid for the duration of the wage loss due to the work- related disability.

(2) Decision. A formal decision containing the basis for OWCP's determination that the employee can perform the duties indicated and that the position is otherwise suitable is issued before benefits are reduced. The decision also shows the formula used to compute the new level of benefits and contains a description of the employee's appeal rights should there be any disagreement with any element of the decision.

D. Disfigurement. In cases where the employee suffers injury to the face, neck, or head, and disfigurement results, the FECA provides for payment of an award of compensation not to exceed $3500 if the disfigurement will likely prove to be a handicap in securing or maintaining employment. As with schedule awards, payment of an award for disfigurement cannot be

considered until maximum medical improvement has occurred. It should be noted that such awards can be considered only for seriously disfiguring scars and deformities.

E. Attendant's Allowance. If an injury is so severe that the employee is unable to care for his or her physical needs, such as feeding, bathing, or dressing, an attendant's allowance of up to $1500 per month may be paid in addition to compensation for loss of wages. The assistance required must be personal in nature; an attendant's allowance cannot be paid for housekeeping services. An employee who believes he or she is entitled to such an allowance should contact the district office by letter for instructions on how to apply for this benefit.

Effective January 4, 1999, all attendants' allowances are paid as medical expenses. A home health aide, licensed practical nurse, or similarly trained individual is to provide the necessary services, including assistance in feeding, bathing, and using the toilet. Like other medical providers, the attendant is to bill OWCP periodically using Form HCFA-1500.

F. House and Vehicle Modifications. An employee whose injury severely restricts mobility and independence in the normal functions of living, either permanently or for a prolonged period, may be entitled to house or vehicle modifications. Examples of such conditions include blindness, profound bilateral deafness, and total loss of use of limbs such that a prosthesis, wheelchair, or leg brace is required. An employee may apply for such modifications by narrative letter. They must be recommended by the attending physician and must be consistent with the employee's pre-injury standard of living.

7-2. Death Benefits

The survivors of a federal employee whose death is causally related to employment are entitled to benefits in the form of compensation payments, funeral expenses, transportation expenses for the remains, if necessary, and payment for termination of the deceased's status as a federal employee.

A. Entitlement. The following individuals are entitled to compensation:
   (1) A widow or widower;
   (2) An unmarried child under the age of 18, or over the age of 18 who is incapable of self-support due to mental or physical disability;

(3) A child between 18 and 23 years of age who has not completed four years of postsecondary education and is regularly pursuing a full-time course of study;

(4) A parent, brother, sister, grandparent, or grandchild who was wholly or partially dependent on the deceased.

B. Compensation Payments. Compensation is paid at the following rates:

(1) A surviving spouse with no eligible children is entitled to compensation at the rate of 50% of the deceased employee's salary. Benefits are paid to the spouse until death or remarriage if he or she is under age 55. If a spouse under age 55 remarries, OWCP makes a lump sum payment equal to 24 times the monthly compensation at the time of remarriage. The benefits of a spouse who remarries after the age of 55 will not be affected by the marriage.

(2) If children are eligible in addition to the spouse, he or she may receive compensation equal to 45 percent of the employee's regular pay, plus an additional 15 percent for each child, to a maximum of 75 percent of the deceased employee's regular pay. The children's portions are paid on a share and share a like basis.

(3) If the deceased employee leaves no spouse, the first child is entitled to 40 percent and each additional child is entitled to 15 percent of the employee's salary, up to a maximum of 75 percent, payable on a share and share alike basis.

(4) Other surviving dependents may be entitled to compensation benefits at various percentages specified by the FECA according to the degree of dependence. Contact the district office for information concerning claims in this category.

C. Funeral and Burial Expenses. Up to $800 will be paid for funeral and burial expenses. If the employee dies away from his or her area of residence, the cost of transporting the body to the place of burial will be paid in full. Itemized funeral bills should be submitted to OWCP for consideration of payment or reimbursement. In addition, a $200 allowance will be paid in consideration of the expense of terminating the deceased's status as a federal employee.

7-3. Dual Benefits

The FECA prohibits payment of compensation and certain other federal benefits at the same time. This prohibition does not, however, prevent an individual from filing for benefits from more than one government program at the same time. For instance, a claimant for disability benefits may file for a retirement annuity, either regular or disability, while his or her claim with OWCP is pending. Similarly, a claimant for death benefits may file for retirement benefits while his or her claim with OWCP is pending. Only if both

benefits are approved will the rules governing dual benefits be invoked.

A. Office of Personnel Management (OPM). Except for schedule awards, a person may not receive disability benefits from OWCP concurrently with a regular or disability annuity--either Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS)--nor may a person receive death benefits from OWCP concurrently with a survivor's annuity (either CSRS or FERS). Therefore, a beneficiary who is entitled to both benefits must elect between them. The election may be offered by either OWCP or OPM depending on the order in which entitlement is determined. An individual may, however, receive disability benefits from OWCP or an annuity from OPM on his or her own behalf along with death benefits from the other agency which are payable on account of a spouse's death.

Either OWCP or OPM may offer the election, depending on which agency determined entitlement first. The beneficiary may change his or her election for different periods of time based on the more advantageous benefits. The beneficiary may change his or her election for different periods of time based on the benefits which are more advantageous. In either case, however, the beneficiary must be fully advised of the amount which will be forthcoming and the nature and frequency of any increases which will accrue so that he or she can make an informed election.

B. Department of Veterans Affairs (VA). Beneficiaries who receive compensation from the VA may also be required to elect between the benefits paid by that agency and those paid by OWCP. Such an election is required when the disability or death resulted from an injury sustained in civilian federal employment and the VA has held that it was caused by military service, or when the VA increases a service-connected disability award due to an injury sustained in federal civilian employment (in the latter case the election involves only the increase in VA benefits due to disability incurred during civilian employment). No election is required between OWCP benefits and those granted by the VA for strictly service-related disability. In death claims, any payment made by the VA for funeral or burial expenses may not be duplicated by OWCP, and the total payable by both agencies may not exceed $800.

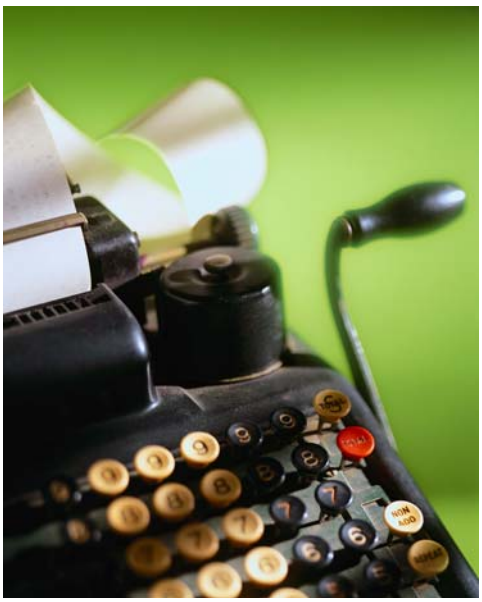
C. Social Security Administration. An employee may receive Social Security payments payable on account of non-federal employment and OWCP benefits at the same time, subject to income limitations imposed by the

Social Security Administration. OWCP will offset Social Security benefits earned on account of federal service.

D. Other Federal Income. An employee may receive compensation concurrently with military retired pay, retirement pay, retainer pay or equivalent pay for service in the armed forces or other uniformed services subject to reduction of such pay in accordance with 5 USC 5532 (b).

An employee may receive severance pay concurrently with compensation for a schedule award or for loss of wage-earning capacity, but not with compensation for temporary total disability. Separation pay may constitute a dual benefit, and an agency which is offering such payments should contact OWCP for further guidance. Finally, an employee may receive unemployment compensation benefits concurrently with OWCP benefits.

7-4. Computing Compensation



While compensation is usually claimed in two-week increments to conform to standard federal pay periods, compensation checks are issued on a weekly or four-weekly basis, depending on the kind of benefit and the length of time benefits are paid. Payments of compensation for very brief periods of temporary total disability or schedule impairment are issued on a weekly basis, while longer-term payments for disability and death are made every four weeks. Checks may be sent to the beneficiary or to a financial institution designated by him or her to receive the funds, but they may not be sent in care of the employee's representative unless guardianship or conservator ship is established.

Compensation payments for wage loss are based on a percentage of the employee's salary (or a statutory pay rate). Payments are computed by multiplying the applicable percentage by the wage rate and increasing the result by any cost-of-living increases to which the beneficiary is entitled.

A. Pay Rate. For both disability and death claims, the pay rate used to compute compensation payments is the one in effect on the date of injury, date of recurrence, or date disability began, whichever is higher. Thus, the pay rate for compensation purposes may change over the life of a claim. The salary used to compute compensation is not affected, however, by general increases in the rate paid for the employee's grade and step. Moreover, the pay rate is not affected by any promotion or raise the employee might have received but for the injury.

B. Additional Elements of Pay. Included in the salary are: night shift; Sunday differential; holiday pay; hazard pay; dirty work pay; quarters allowance and post differential for overseas employees; and extra pay authorized by the Fair Labor Standards Act (FLSA) for employees who receive annual premium pay for standby duty and who also earn and use leave on the basis of their entire of tour of duty, including periods of standby duty. Overtime pay is not included, however, except for administratively uncontrollable work covered under 5 USC 5545(c)(2).

The supervisor should report these elements of pay by indicating the weekly or biweekly amount, if the employee has a regular schedule. Otherwise the supervisor should compute and submit to OWCP the doll amount paid in each category for the calendar year preceding the effective date of the pay rate.

C. Compensation Rate. The compensation rate is the percentage applied to the salary in order to determine the monetary amount of the compensation payment. These rates are described in Chapter 7-1 for disability cases and 7-2 for death cases.

D. Cost-of-Living Increases. Each March 1 the increase in the cost of living for the preceding calendar year is determined. If the beneficiary has been entitled to compensation for at least one year prior to March 1, a cost-of-living increase is applied to the benefits.

E. Minimum and Maximum Rates. The law provides for minimum and maximum payments of compensation.

(1) Disability. Compensation for temporary total disability or schedule awards may not exceed 75 percent of the monthly salary of an employee at the highest step of the GS-15 level. For total disability, it may not be less than 75 percent of the monthly salary of an employee at the first step of the GS-2 level or actual pay, whichever is less.

(2) Death. Compensation for death may not exceed 75 percent of the highest step of the GS-15 level, and it may not be less than the minimum pay of the first step of the GS-2 salary. In no case may it exceed the employee's salary except when the excess is created by cost-of-living increases.

F. Buy-back of Leave. Compensation entitlement for leave repurchase is computed in the same way as compensation for temporary total disability. Because leave is paid at 100% of the usual wage rate and compensation is paid as a percentage, the employee will generally owe the agency money for the leave repurchased.

Form CA7a is used when dates of leave are intermittent or when more than one continuous period of leave is claimed. Form CA-7b explains how leave is repurchased and asks the agency to estimate the amount of compensation payable. The agency should advise the employee of the amount it requires for reinstating the leave and agreeing to the transaction before submitting the Form.

When OWCP advises the employee and the agency of the amount payable, the employee should consult with the agency to determine how much money he or she will need to repay. The amount to be recovered by the agency should be the value of the salary or wages paid to the employee while in a leave status. If the employee wishes to complete the transaction, the agency and employee will decide whether the compensation should be paid directly to the employee or refunded to the agency. The agency will be asked to state the amount paid to the employee for the leave to be repurchased; this amount may be either net or gross.

G. Lump Sum Payments. The FECA was designed to provide for the periodic payment of compensation in order to ensure that beneficiaries have a continuing source of income to offset wage loss. With few exceptions such benefits are free from speculation, fluctuation, and attachment by creditors, and they are also generally free from taxes. Lump sum payments of compensation will be considered only for payments of schedule awards or survivors' benefits to widows or widowers who remarry before age 55.

H. Incorrect Payments. An employee who receives a compensation payment which he or she knows to be incorrect, either partially or totally, should return the check to OWCP immediately. If an overpayment occurs, OWCP will determine whether the beneficiary is with fault in creation of the overpayment. Only if a beneficiary is determined to be without fault may waiver of the overpayment be considered.

I. Health Benefits. OWCP will make deductions for health benefits coverage for beneficiaries who are entitled to continue their enrollment. Deductions cannot be made for periods less than 14 days, and compensation must be paid for at least 28 days in order for deductions to be made.

(1) Criteria. The following requirements must be met to continue enrollment:

(a) Disability. An employee may continue enrollment if he or she was enrolled (or covered as a family member) in a health benefits plan during the five years of service immediately preceding the start of compensation; during all service since his or her first opportunity to enroll; or continuously for the full period or periods of service beginning with the enrollment which became effective not later than December 31, 1984.

(b) Death. A beneficiary in a death case may continue enrollment if the three conditions noted above have been met and, in addition, the deceased employee was enrolled for self and family at time of death and at least one covered family member is receiving compensation from OWCP.

(2) Transfer. If the beneficiary will likely be on OWCP rolls for longer than six months, transfer in will be requested from the employing agency. If an employee returns to duty, the enrollment will be transferred back to the agency even if he or she is receiving compensation for loss of wage-earning capacity. If compensation benefits are terminated or if the employee elects an annuity from OPM over benefits from OWCP, OWCP will transfer enrollment to OPM. Similarly, enrollment will be transferred to OPM for a retired employee who is receiving a schedule award.

Beneficiaries are entitled to change health benefits plans during open season in the same manner as other federal employees.

J. Optional Life Insurance (OLI). Basic life insurance is continued at no cost to the employee while he or she is receiving compensation unless the employee has elected Post-Retirement Basic Life Withholdings at 100% or 50% of the original value. An employee may retain OLI while receiving compensation if he or she is eligible to continue regular insurance and has been enrolled for no less than the five years of service immediately preceding the disability, or the full period or periods of service during which OLI was available, if less than five years.

The agency determines eligibility for OLI. Therefore, when question "c" of section 10 on Form CA-7 is checked "yes", OWCP considers the employee eligible for continued coverage, as long as the employee is considered unable to return to duty. Questions about basic life insurance coverage should be referred to OPM, while questions about OLI may be directed to OWCP.

CHAPTER 8. MANAGING DISABILITY CLAIMS

This chapter describes how OWCP manages disability claims, including reemployment of partially disabled employees. It also describes the sanctions applied to employees who do not cooperate with this effort.

8-1. Initial Actions by OWCP

Where it appears that disability will continue for at least 60 days, the employee is placed on the short-term roll, advised that payment is being made, and asked when he or she plans to return to work, if this has not already occurred. An employee who has not returned to full duty, or who does not have plans to do so within the immediate future, is referred to an OWCP Staff Nurse.

The employee is advised that compensation will continue only through the date specified by OWCP's medical matrix or other procedural guidance or 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 the agency concerning the availability of light duty.

At the same time, the agency is asked 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. Information concerning the employee's earnings and dependents will be requested periodically during the course of disability.

When the medical evidence shows that total disability has ended, the employee will be advised that he or she is expected to seek work. In accordance with the provisions of 5 USC 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.

8-2. Restoration Rights

Federal employees who have fully or partially recovered from an employment-related injury have certain job retention rights. While these rights are provided by the FECA, the pertinent section of the law is actually administered by OPM. An employee who recovers within one year of beginning compensation has mandatory restoration rights to his or her old position or its equivalent, regardless of whether he or she is still on the agency rolls. If full recovery occurs after one year, or the employee is considered partially recovered, he or she is entitled to priority consideration provided that application is made within 30 days of the date compensation ceases.

Such employees incur no loss of benefits which they would have received but for the injury or disease. The regulations on retention rights are contained in 5 CFR

353, 302, and 330. These sections of the regulations are administered by OPM, not OWCP. Any period of time during which an employee receives compensation from OWCP is credited to the employee for the purpose of determining rights and benefits based upon length of service, including eligibility to retirement.

When an injured employee resumes federal employment, the agency should verify that the employee had been receiving compensation during the entire period of absence from work whether in LWOP status or separated. Employees originally hired on or after January 1, 1984 are covered for retirement purposes by the Social Security Act rather than the Civil Service Retirement Act (CSRA). An employee hired before that date will retain CSRA coverage if reemployed by a federal agency, regardless of the length of time he or she has been receiving compensation, and regardless of whether he or she is in LWOP status or separated.

An employee who has applied for and been approved for federal retirement benefits is no longer considered an employee, and any reemployment is covered by OPM rules and regulations for reemployment annuitants. This is true even if the employee never actually received a federal retirement annuity.

OWCP's case management procedures emphasize return to work before the expiration of the employee's one-year entitlement to the same or an equivalent job.

8-3. Nurse Services

Independent studies and OWCP's own experience both indicate that the use of nurses may shorten periods of disability and increase the likelihood of return to work. Registered Nurses (RNs) under contract to OWCP meet with employees, physicians, and agency representatives to ensure that proper medical care is being provided and to assist employees in returning to work.

OWCP offers this service to all employees with approved traumatic injury claims who have continuing disability, and on a selective basis to employees with approved occupational illness claims who have continuing disability.

A. Contacting the Interested Parties. The RN contacts the employee, attending physician, and supervisor as needed to address the employee's questions about medical care; obtain treatment plans, return to work dates, and descriptions of work limitations; and explore availability of light duty

jobs. These contacts, which may be by telephone or in person, generally occur after the 45 day COP period has ended.

B. Return to Work. Conference calls may be held to arrange for the employee's return to work. Such a call should always include the agency official who has the authority to offer a light duty job. When an employee returns to work, the RN may accompany him or her on a walk-through of the job to ensure that the duties are within the employee's work limitations and that both the employee and the supervisor understand the duties and limitations.

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

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

8-4. Reemployment with the Agency

When the medical evidence shows that total disability has ended, the agency may consider reemployment even if notification from OWCP has not yet been received. The following procedures apply to all employees still on agency rolls, regardless of how long they have received compensation.

A. Medical Evidence. To make an appropriate job offer, the agency will need medical evidence pertinent to the employee's work tolerance limitations (in some cases OWCP will provide this information). Medical information which addresses current medical limitations will usually be sufficient for the purpose of making a job offer. If the employee refuses to provide sufficient medical information for the agency to evaluate the propriety of a job offer, the agency should so notify OWCP.

B. Degree of Recovery. If the employee is expected to return eventually to the job held at the time of injury, the agency may offer light or modified duty pending full recovery. Any such offer should be made in accordance with the procedures outlined in paragraph d below. If the residuals of the injury will prohibit the employee from returning to the position held at the time of injury and the employee has received compensation for more than one year, the agency should consider reemployment in the following order of preference:

(1) Return to the position held at the time of injury with modifications to accommodate the employee's limitations;

(2) Employment in another position at the same salary as the position held at the time of injury; or

(3) Employment in another position at a lower salary than the position held at the time of injury.

C. Guidelines for Reemployment. In identifying potential jobs, the agency should try to minimize any disruption to the employee. The position should be compatible with the employee's medical condition and should take into account any non-work-related medical condition, which either pre-existed the work-related injury or has developed since it occurred. If a temporary position is offered, it must be at least 90 days in duration.

Generally, an employee who is capable of working four or more hours a day should be offered a position providing at least that much work, since employment of less than four hours a day is regarded as sheltered work and is reserved for the severely disabled. (On the other hand, an offer of less than four hours work a day is suitable for an employee who cannot work longer hours.) As much as possible, the tour of duty and location of the identified job should correspond to those of the job held on the date of injury. The agency must ensure that any position offered will be available throughout the period required to allow him or her to respond.

D. Elements of Job Offer. The agency may contact the employee by telephone to advise that the job is available, but the offer must be confirmed as soon as possible in writing. A copy of the offer must be sent to the OWCP at the same time. The offer should include:

(1) A description of the duties to be performed;
(2) The specific physical requirements of the position and any special demands of the workload or unusual working conditions;
(3) The organizational and geographical location of the job;
(4) The date on which the job will be available;
(5) The date by which a response to the job offer is required.

The agency should not, however, request election of OPM benefits if the employee declines the job offer. Obtaining such an election is solely the responsibility of OWCP.

E. Advising the Employee. If the job offer is found to be suitable, and it fairly and reasonably represents the employee's wage-earning capacity, OWCP will so notify the employee in writing and advise that he or she is expected to accept the job or to show reasonable cause for refusal. OWCP will advise the employee that the failure to accept the job or to respond

within 30 days will result in termination of compensation payments and allow 30 days for response.

F. Employee's Response. The agency should provide a copy of the employee's response to OWCP when it is received.

(1) Acceptance. If the employee accepts the job, the agency should notify OWCP as soon as possible of the date of return to duty so as to avoid overpayments of compensation. If the employee accepts the position offered, compensation will be terminated if no loss of pay has resulted, or reduced if the new job pays less than the old, effective the date of return to duty.

(2) No Response. If no answer is received, benefits will be terminated and a formal decision will be issued on the basis that the employee has refused suitable work.

(3) Refusal with No Explanation. If the employee refuses the offer without explanation, OWCP will issue a formal decision and terminate benefits.

(4) Refusal with Explanation. If the employee refuses the offer but provides reasons in support of the refusal, OWCP will evaluate them and determine whether reasonable cause has been shown. If reasonable cause is shown, OWCP will advise the employing agency and compensation will continue at a level reflecting the degree of disability while further attempts at placement are made. If not, the employee will be so advised and allowed an additional 15 days to return to work. If the employee still does not return to work, a formal decision will be issued and benefits will be terminated.

The success of efforts to return employees to gainful employment while providing procedural due process requires close cooperation between employing agencies and OWCP. Early notification of job offers and complete information about the offers will aid OWCP in making its decisions. For its part OWCP recognizes its responsibility to evaluate job offers and to notify employees quickly to avoid undue delays.

8-5. Vocational Rehabilitation Services

The FECA at 5 USC 8104 provides that vocational rehabilitation services may be provided to disabled employees to assist them in returning to gainful employment consistent with their physical, emotional, and educational abilities. An employee with extended disability may be considered for rehabilitation services if requested by the attending physician, the employee, or agency personnel. In addition, OWCP will routinely consider a case for rehabilitation services if the agency cannot reemploy the employee so that placement with another employer may be considered.

A. Services Provided. An OWCP Rehabilitation Specialist will contact the employee for an initial interview. The employee will then be referred to a state or private Rehabilitation Counselor for development of a rehabilitation plan. A plan may include one or more of the following services: selective placement with the previous employer, placement with a new employer, counseling, guidance, testing, work evaluations, training, and job follow-up. Each employee is evaluated to provide the most appropriate services to him or her, and not all of the services indicated will be included in any given plan.

B. Advice to Employee. When suitable jobs are identified, the employee will be advised that it appears that he or she has a wage-earning capacity of a specific dollar amount which will likely determine future compensation entitlement; that he or she is expected to return to work in a job similar to the one identified, and that only partial compensation based on the wage-earning capacity of the indicated job will probably be paid at the end of this effort; and that when any necessary training or other preparation is completed, OWCP will provide 90 days of placement services.

C. Benefits Payable. An employee in an approved vocational rehabilitation program may be paid an allowance in connection with this program not to exceed $200 per month. The employee is also entitled to compensation at the rate for total disability during the rehabilitation program (payment of a schedule award meets this requirement). When the employee returns to work, compensation will be reduced to reflect his or her wage-earning capacity if the new job pays less than the old. If reemployment is at the same or higher pay rate than the job held at time of injury, compensation benefits will be terminated. Even if the employee does not return to work, his or her compensation will in all likelihood be reduced.

D. Penalties. Should an employee involved in a rehabilitation program refuse to cooperate or make a good faith effort to obtain reemployment, OWCP may reduce or terminate compensation depending on the circumstances of the refusal.

E. Constructed Positions. In some situations reemployment is not feasible despite the best efforts of both the employee and OWCP. When this happens, the employee's wage-earning capacity may be determined on the basis of a position which the medical evidence indicates the employee can perform and which is available in his or her commuting area. The suitability of the position must be determined in accordance with the following factors:

(1) The nature of the injury;
(2) The degree of physical impairment;
(3) The usual employment;
(4) The employee's age;
(5) Qualifications for other employment, including education, previous employment, and training.

OWCP will issue a formal decision, including appeal rights, will be issued in any case where the benefit level is affected.

F. Continued Disability Payments. Only after aggressive medical and vocational development will OWCP determine that an employee has no current wage-earning capacity, and should therefore be carried on the long-term compensation rolls at the rate for total disability.

8-6. Assisted Reemployment

As part of a demonstration project, the OWCP may reimburse an employer who was not the employer at the time of injury for part of the salary of a reemployed worker. This wage subsidy is intended to assist in reemploying workers who have been difficult to place with their former employers. It is available to other federal employers as well as to State and local governments and the private sector.

A. Eligibility. To be eligible, the agency cannot have been the worker's employer at the time of the injury, as identified by OWCP chargeback billings, appropriations account number and agency hiring authority. Intra-departmental salary reimbursements are limited to agencies with a separate appropriation number from that of the employing agency at the time of injury. It is not proper to use the assisted reemployment approach for transfers within the agency, or where an agency uses more than one appropriation number but hiring is controlled at a higher organizational level.

B. Conditions of Participation. The rate of reimbursement may not exceed 75 percent of the employee's gross wage. The actual rate of reimbursement available must therefore be decided on a case-by-case basis by OWCP staff in negotiation with the agency. Salary reimbursement may extend for up to 36 continuous months, but it may not be interrupted by a recurrence of disability due to the accepted condition. The subsidy may not be transferred from one employer to another.

An agency interested in participating in the Assisted Reemployment project should contact the District Director or a Rehabilitation Specialist at the regional OWCP office. Where a job opening has been identified which may be suitable for a particular worker, the Rehabilitation Counselor assigned to that worker will meet with agency personnel to explain details of the program.

For OWCP to consider reimbursement of salary expenses, the job offer must be found suitable, medically and otherwise (see paragraph 5 above). To make such a finding, OWCP needs several items of information, including a copy of the position description which includes a statement of the physical requirements of the job. With this information, OWCP staff will make a suitability determination.

C. Elements of Agreement. When the worker accepts a suitable job offer, the new employing agency and OWCP will enter into an Assisted Reemployment Cooperative Agreement. Each Agreement will include the following elements:

(1) Employee's name and OWCP claim number;
(2) Employer's name and address;
(3) A description of the procedures for claiming reimbursement and the payment schedule, including the method and maximum amount of wage reimbursement payments from OWCP to the employer for each employee hired under the project;
(4) A job description and statement of starting wage rate.

D. Transfer of Funds. Once agreement is reached concerning financial and administrative arrangements, OWCP staff will contact the agency to determine the most effective method of payment and transfer of funds. The preferred method of reimbursement by the OWCP is through the U. S. Treasury's GOALS/OPAC (On-Line Payment and Collection) system. Agencies which do not process payments through the U.S. Treasury, OWCP will reimburse by check.

OWCP will then advise the agency in writing of the specific accounting procedures for transferring funds. Payment is made after OWCP receives an authorizing document certifying that the employee was actually employed and received wages during the quarter for which reimbursement is requested. Regardless of the method of reimbursement, OWCP will require quarterly submission of records of the wages paid to these reemployed workers and the periods covered by those payments.

8-7. Payment of Relocation Expenses

OWCP's regulations provide at 20 CFR 10.508(f) that an injured employee who relocates to accept a suitable job offer after termination from the agency rolls may receive payment or reimbursement of moving expenses from the compensation

fund. This regulation further states that federal travel regulations (issued by GSA) pertaining to permanent change of duty station moves are to be used as a guideline in determining whether expenses claimed are reasonable and necessary.

A. Locations of Old and New Jobs. Relocation expenses may be paid for a former employee who is partially recovered from compensable injury and who is offered a job in either the same or a different commuting area from the former one. OPM regulations governing the restoration rights of injured workers require consideration of partially recovered employees only in the former commuting area. Thus, the extent to which an agency considers partially recovered employees for jobs outside the commuting area is a matter for agency personnel to decide.

Former employees who move voluntarily to other locations and are offered reemployment at their former installations are generally not entitled to payment of relocation expenses. (See GSA's Federal travel regulations and pertinent Comptroller General's decisions which address relocation in the Government's interest.) The extent to which relocation expenses are payable when a fully or partially recovered employee is still on the agency's rolls is governed by federal travel regulations pertaining to permanent change of duty station moves.

However, OWCP's regulations state specifically that "the agency may offer suitable employment at the employee's former duty station or other alternate location" and that relocation expenses will be payable in either case. Therefore, employing agencies should not discourage applications for payment of relocation expenses to the previous duty station. Given the considerable savings in compensation costs which accrue to employing agencies which return their injured workers to the rolls, payment of relocation expenses to the original duty station are considered to be in the interest of the Government.

B. Eligibility. The distance between the two locations must be at least 50 miles, and the job must be found medically and vocationally suitable. OWCP will authorize payment of expenses incurred to accept a temporary position as long as it is expected to lead to a permanent assignment. The employee need not demonstrate financial need for relocation expenses to be paid, and payment/reimbursement of relocation expenses may be

considered after the fact as long as the move took place after June 1, 1987, the effective date of the provision governing such moves.

OWCP staff will determine whether relocation expenses can be approved and will notify the employee and agency personnel. While payment by the agency with reimbursement by OWCP through the U. S. Treasury's GOALS/OPAC (On-Line Payment and Collection) system is preferred, direct withdrawal from the compensation fund may be authorized where necessary.

C. Arranging the Move. Because employing agencies have expertise in arranging PCS moves, OWCP will ask the agencies to calculate the costs and coordinate the activities involved in such moves insofar as possible. OWCP will be responsible for resolving any disputes between the employee and the agency as to allowable costs in accordance with government travel regulations.

D. RITA Payments. The IRS considers at least a portion of PCS payments to be reportable as income even though such payments are intended to reflect actual expenses, and employing agencies usually include a Relocation Income Tax Allowance (RITA) to offset the additional income tax liability incurred because of PCS reimbursements. Compensation benefits are not considered taxable, however, and for this reason the RITA should not be included in paying relocation expenses under the FECA.

8-8. Employees in Light Duty Status

Many agencies place both newly injured and long-term disabled employees in light duty jobs. Such placements usually benefit both employers and employees. However, when employees continue to hold light-duty assignments after they are able to return to full duty, the availability of such light duty assignments for more recently injured employees is decreased. Therefore, it is the policy of OWCP to monitor injured employees who hold light duty jobs until they have returned to full duty, or until the medical evidence firmly establishes that they will never be able to return to full duty. Employing agencies can aid in this effort by identifying employees who have been in light duty status for over three months.

8-9. Separation from Employment

A. Reductions in Force. When a formal loss of wage-earning capacity has been determined, the employee has the burden to establish further entitlement to compensation. Therefore, the status of an employee with an established wage-earning capacity who is removed due to an across-the-board reduction in force (RIF) or the closing of an installation (as opposed to the elimination of only light duty jobs) does not change with regard to receipt of FECA benefits unless a formal claim for recurrence is filed. When no formal finding with regard to wage-earning capacity has been made, and the employee has worked in the position for at least 60 days,

OWCP may consider a retroactive loss of wage-earning capacity determination.

B. Removal for Cause. An employee who is separated for misconduct and whose removal is wholly unconnected to the work-related injury is not entitled to further compensation benefits.

CHAPTER 9. AGENCY MANAGEMENT OF COMPENSATION CLAIMS

This chapter describes actions agency personnel may take to learn more about individual claims of current and former employees, and to manage their compensation programs.

9-1. Obtaining Information.

Agencies have several options for contacting OWCP:

A. Agency Query System (AQS). This system allows federal employers such as the Department of the Interior to access data for their employees through the Internet, which contains data on current case status, compensation payments, and medical bill payments for all active cases. This system can be accessed at the following website: https://aqsweb.dol-esa.gov/AQS/resources/index.html.

B. Interactive Voice Response (IVR). This system allows callers to access several kinds of information using their telephone keypads. The IVR provides callers with information about submitting medical bills for reimbursement and filing claims. It also allows callers to query the program's data base for the status of medical bills, the date of the last compensation payment, and other case specific information.

C. Telephone. Most district offices have Contact Representatives who can provide information on the status of a claim and answer general questions. When more detailed information is needed, the Claims Examiner responsible for the case file often satisfies the inquiry.

A supervisor with questions about common themes identified in a number of claims should contact the Assistant District Director or District Director for clarification. Only inquiries which cannot be resolved in this way should be referred to OWCP's National Office, and any such matter should be referred through the agency's headquarters. Policy questions may also be referred to OWCP's National Office.

9-2. Inspection and Protection of Records.

Claims personnel are instructed to provide agency personnel with copies of all significant correspondence to employees, even when the employees are no longer on the agency's rolls. Under the routine use provisions of the regulations governing release of information under the Privacy Act, agencies are entitled to obtain copies of other materials in their employees' compensation files as well.

The use of these copies must, however, be consistent with the reason the information was collected. In practice, this means that the use must generally be connected in some way with the compensation claim. Agencies may not use copies form claim files in connection with EEO complaints, disciplinary actions,

or other administrative actions without the employee's consent. Any questions concerning use or release of records should be directed to the district office.

To safeguard the privacy of information in compensation files, much of which is inherently sensitive, the following procedures are followed:

A. Making Specific Requests. Requests from the agency for materials in a case file should include the specific reason for requesting the information (e.g., to verify that the employee actually worked for the agency, or to attempt reemployment of the worker). OWCP will release the requested information either by telephone or in writing once satisfactory identification is presented. (This requirement needs to be met only once if an agency designates a particular individual as a liaison or principal contact with the district office.) Representatives of an investigative body within an agency may also obtain information upon presentation of proper identification as long as the purpose for the request is stated.

B. Inspecting Files. An agency representative may ask to inspect files at the district office. All such requests will be accommodated subject to logistical and physical limitations, including reasonable advance notice of the visit and a list of cases to be reviewed. Here again, the purpose should be stated specifically and the identity of the reviewer should be established in advance of the visit. A picture ID must be presented at the time of the visit unless the reviewer is known to the office. Generic requests will be honored when several cases are to be inspected for the same reason.

C. Penalties under the Privacy Act. It is not appropriate for agency personnel to inspect records without a specific and valid purpose for doing so (that is, curiosity is not an acceptable reason for review). Agency personnel who review files should be conversant with the restrictions of the Privacy Act and the penalties stipulated for violations. These penalties include fines and imprisonment. Any individual who improperly uses information from OWCP files will not be given further access to them.

D. Contractors. If the agency wishes to designate a private contractor to inspect the records, the agency should contact the OWCP National Office in writing to obtain approval for the arrangement. The agency should ensure that the contractor observes the pertinent regulations governing the privacy of employees' records as they review the files and report their findings to the agency.

9-3. Managing Compensation Programs

Agencies are encouraged to develop comprehensive plans for managing their compensation programs to provide good service to employees while containing costs. Ideally, management of compensation claims should be considered personnel rather than a safety and health function.

Throughout this handbook, numerous suggestions and directives have been provided to help agencies to manage their programs. The following is a summary of the most important actions agencies can take:

A. Training. Ensure that sufficient training in technical and managerial skills is provided to those personnel who routinely handle compensation claims and that resource materials are avail-able to those who handle them infrequently. A list of the courses provided and resources for understanding the program is provided in Chapter 1.

B. Administration. Establish a record-keeping system which will enable the agency to maintain copies of claim forms, medical reports, correspondence with OWCP, and other materials related to each compensation claim in an orderly fashion. Designate a representative within each organizational unit who will serve as a liaison with OWCP concerning unusually difficult claims.

C. Documentation. Ensure that the facts surrounding each injury are adequately investigated at the time of injury. This step will enable OWCP to obtain full documentation and enable agencies to substantiate claims it feels are questionable.

D. Medical. Obtain medical information from OWCP or injured employees as often as necessary within OWCP and OPM regulations to assess the possibility of return to regular or light duty. Advise physicians of any light duty assignments available and their specific requirements to provide the best possible chance for reemployment. This step will also allow the agency to monitor the medical care provided and notify OWCP if it believes action should be taken in this regard.

E. Reemployment. Maintain contact with injured employees while they are receiving compensation, identify jobs suitable for them, and initiate efforts to reemploy recovered or recovering employees as soon as the medical evidence indicates that this is possible.

F. Financial. Conscientious application of the above principles will result in savings to the agency and better service to injured employees. Agencies should also pay special attention to chargeback billings and arrange to charge costs to the lowest organizational level practicable to make

managers more aware of costs. The chargeback system is discussed in detail in paragraph 9-4.

9-4. Record-Keeping

Employing agencies often retain documents in connection with workers' compensation claims. Rules governing release, retention, and disposal of such records differ according to the nature and source of the document involved.

A. Documents in Employee Medical Folder (EMF). A notice of injury not filed with OWCP is to be placed in the employee's EMF and retained in accordance with OPM regulations governing disposal of the EMF.

B. Documents in OWCP Case File. These documents include medical reports, copies of letters and decisions, and any other material which is part of the case file, regardless of its source. The agency may use and release such material consistent with the provisions of the Privacy Act, and consistent with the reason for which the material was collected. It may not be used in connection with EEO complaints, disciplinary actions, or other administrative actions without the employee's consent. Any questions concerning use or release of records should be directed to the district office with jurisdiction over the claim. These documents should be maintained in folders apart from the EMF or OPF, but such folders are not considered a "system of records" separate from the case file. Rather, they are considered an alternate location for the records, which remain under the jurisdiction of the OWCP. Their retention and disposal is covered by the OWCP Records Retirement Schedule, which mandates that case file material should be maintained for two years after case closure.

9-5. Chargeback

The FECA program is financed by the Employees' Compensation Fund, which consists of monies appropriated by Congress or contributed from operating revenues. The chargeback system is the mechanism by which the costs of compensation for work-related injuries and deaths are assigned to employing agencies annually at the end of the fiscal accounting period, which runs from July to June for chargeback purposes. Each year OWCP furnishes each agency with a statement of payments made from the fund on account of injuries suffered by its employees. The agencies include these amounts in their budget requests to Congress. The resulting sums appropriated or obtained from operating revenues are deposited in the Fund.

A. Identification. A compensation claim is identified as belonging to a particular agency based on the agency code that is entered into the OWCP data processing system when the case is created. The agency should pre-

code all initial notices of injury, disease and death in order to reduce errors in the chargeback system. The agency will receive a postcard (Form CA-801) from OWCP each time a case is created for one of its employees. OWCP also provides each agency quarterly listings of the cases and charges that will appear on the yearly chargeback bill.

B. Errors. To prevent incorrect entries from appearing on the quarterly chargeback report and yearly bill, agencies should review Forms CA-801 and report errors to district offices as soon as possible. If no objection is raised upon receipt of the form, OWCP assumes that the chargeback code is correct and charges costs associated with the case to that agency's account.

If an agency which receives a Form CA-801 which it believes to be incorrect, it should notify OWCP in writing within 60 days. The district office will then review the disputed case to determine whether a keying or coding error occurred and make any necessary corrections to the agency code.

C. Quarterly Chargeback Report. Each agency receives a quarterly report which provides a breakdown of cases and costs for which charges will appear on the yearly chargeback bill. This report can be used to identify and correct errors before the agency is billed for them. When an agency believes that a case appearing on its chargeback report does not belong on its account, it should check current personnel and payroll records as well as search the service record file and/or send an inquiry to the Federal Records Center. OWCP also welcomes authorized agency personnel to review case files at the district office to resolve such discrepancies.

D. Requesting Changes. Requests for changes based on review of the quarterly chargeback report should be addressed to the District Director of the district office having jurisdiction over the case in question. The request should be made within 90 days of receipt of the report, and it must be accompanied by appropriate documentation such as copies of an SF-50, service record card (SF-7), or response from the Federal Records Center. OWCP will review the case file and supporting evidence to determine whether an incorrect agency code was assigned. If the evidence does not support the agency's request, OWCP will send the agency a copy of the Form CA-1, CA-2, or CA-6 from the case file and explain the basis for its finding.

If the evidence indicates that the disputed case belongs on another agency's account, OWCP will notify the new agency and forward a copy of Form CA-1, CA-2 or CA-6 from the case file. Prior to changing the agency code, OWCP will provide the agency 60 days to respond in the event that it disputes ownership of the case. Due to the time needed for verification and correction, errors brought to the attention of OWCP during the fourth quarter of a fiscal year may not be corrected in time for that year's bill. If incorrect charges appear on the bill, adjustment will be handled as described below.

If the assigned chargeback code represents the wrong organization or command within the agency, the request for change of code must be made by an agency official with the authority to speak for the entire department rather than for a single command or organizational unit.

E. Adjustments to the Chargeback Bill. When an adjustment to the yearly chargeback bill is desired, the request must be sent directly to the OWCP National Office. It must be accompanied by documentation which shows that the disputed charge did not involve an employee of that agency, or by a complete explanation of the basis for the agency's objection. OWCP will make a determination and correct verified errors by crediting the subsequent year's billing statement.

If another agency should have been charged, OWCP will so notify that agency and a debit will appear on its next bill. Credits or debits will be made only for charges appearing on the agency's most recent bill. Adjustments will be made only if there is an effect on the total for the particular billing entity. Transfers of charges from one organization to another on the same bill will not be made.

Appendix A: OWCP 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 occupation

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

a. Occupation code

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

b. Type code

c. Source code

OWCP Use - NOI Code

Employee Signature

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

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

☐ b. Sick and/or Annual Leave

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

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

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

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

Witness Statement

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

Name of witness

Signature of witness

Date signed

Address

City

State

ZIP Code

Form CA-1
Rev. Apr. 1999

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

Supervisor's Report

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

OSHA Site Code

ZIP Code

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

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

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

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

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

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

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

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

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

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

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

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

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

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

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

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

Name of supervisor (Type or print)

Signature of supervisor | Date

Supervisor's Title | Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

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

Instructions for Completing Form CA-1

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

Employee (Or person acting on the employees' behalf)

13) Cause of injury

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

14) Nature of Injury

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

15) Election of COP/Leave

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

Supervisor

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

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

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

17) Agency name and address of reporting office

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

18) Duty station street address and zip code

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

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

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

32) Name and address of physician first providing medical care

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

33) First date medical care received

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

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

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

a) The disability was not caused by a traumatic injury.

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee Is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

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

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

OWCP Agency Code

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

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 M

5. Home telephone

6. Grade as of date of last exposure Level Step

7. Employee's home mailing address (Include city, state, and ZIP code)

8. Dependents
- Wife, Husband
- Children under 18 years
- Other

Claim Information

9. Employee's occupation

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (include City, state, and ZIP code)

11. Date you first became aware of disease or illness Mo. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr.

13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness

OWCP Use - NOI Code

b. Type code

c. Source code

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

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

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

Employee Signature

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

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

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

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

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

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

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

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

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

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

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

(4) Vocational rehabilitation and related services where necessary.

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

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

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

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

Privacy Act

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

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

Receipt of Notice of Occupational Disease or Illness

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

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

At (Location)

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

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

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

Supervisor's Report

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

OWCP Agency Code

OSHA Site Code

ZIP Code

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

ZIP Code

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

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

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

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

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

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

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

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

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

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

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

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

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

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

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

Name of Supervisor (Type or print)

Signature of Supervisor

Date

Supervisor's Title

Office phone

INSTRUCTIONS FOR COMPLETING FORM CA-2

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

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

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

1) Employee's statement

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

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. if so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Detailed description of the physician's findings.

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

e) Diagnosis.

f) Clinical course of treatment.

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

3) Wage loss

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

Supervisor (Or appropriate official in the employing agency)

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

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

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

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

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

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

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

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

14. Nature of the disease or illness

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

19. Agency name and address of reporting office

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

23. Name and address of physician first providing medical care

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

24. First date medical care received

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

32. Employee's Retirement Coverage.

Indicate which retirement system the employee is covered under.

33. Was the injury caused by third party?

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

Employing Agency - Required Codes

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

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

OWCP Agency Code

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

• U.S. GPO: 2001480-204/59062

Notice of Recurrence

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

Employee: Complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0167
Expires: 07-31-08

Part A - Employee

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. OWCP file number for original injury
4. Date of birth Mo. Day Yr.
5. Sex ☐ Male ☐ Female
6. Home telephone
7. Home mailing address (include city, state, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other
9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)
10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
11. Date and Hour of original injury (mo., day, year)
12. Date and Hour of recurrence (mo., day, year)
13. Date and Hour stopped work after recurrence (mo., day, year)
14. Date and Hour pay stopped after recurrence (mo., day, year)
15. Date and Hour returned to work (mo., day, year)
    - ☐ Medical Treatment Only
    - ☐ Time Loss From Work
17. Date of first medical treatment following recurrence (mo., day, year)
18. Name and address of treating physician
19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) ☐ Yes ☐ No
20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

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

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

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

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

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

Part C - Employee

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

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

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

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

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

   $ _____ per _____

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

   If so, for what period? _____ through _____.

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

   If so, how much and from what source? _____

NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 to the U.S. Code. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee	8. Date (mo., day, year)

• U.S. GPO: 2000-467-602/39549

Part B - Federal Employing Agency

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

OWCP Agency Code

ZIP Code

OSHA Site Code

26. Employee's duty station (street address and ZIP Code)

ZIP Code

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

Mo. Day Yr.

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

29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

30. Date of injury Mo. Day Yr.

31. Date of recurrence Mo. Day Yr.

32. Date stopped work after recurrence Mo. Day Yr. Time ☐ a.m. ☐ p.m.

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

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

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

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

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? ☐ Yes ☐ No

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

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

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

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

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

INSTRUCTIONS FOR COMPLETING FORM CA-2a
NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

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

A Recurrence of Disability is a work stoppage caused by:

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

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

INSTRUCTIONS FOR EMPLOYEE

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

INSTRUCTIONS FOR EMPLOYING AGENCY

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

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

Who Should File Claim	● This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.
When Should Claim Be Filed	● Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	● The marriage certificate(s) for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also, if appropriate, Letter of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	● All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-13 the surviving widow or widower; 14-14a, surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	● Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

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

Attending Physician's Report

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

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

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

7. What was the direct cause of death?

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

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

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

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

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

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

OMB No. 1215-0155
Expires: 05-31-2007

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number

6. Name and address of employing agency (Include ZIP Code)	7. Nature of injury which caused death

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

8. Name and address (Include ZIP Code)	9. Your Date of Birth (Mo., day, year)	10. Date of Marriage to Employee (Mo., day, year)

11. Were you living with the employee at time of death?	12. Were you ever married to anyone other than the employee?	13. Was employee ever married to anyone other than yourself?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

Name	Relationship	Date of Birth	Address (Include ZIP Code)

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

Name	Relationship	Date of Birth	Address (Include ZIP Code)

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

Child	Guardian	Guardian's Address (Include ZIP Code)

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

Name	Relationship	Date of Birth	Address (Include ZIP Code)

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

Retirement System ☐ CSRS ☐ FERS ☐ SSA ☐ Other

Claim Number for each claim: a. b.

Date each benefit began: a. b.

Amount of each benefit paid per month: $ a. b.

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

Service number: VA Claim number:

Address of VA office where claim is filed:

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

Amount of recovery: $

Name and address of third party:

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

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

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

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

Widow or Widower

- To quality for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or later, no lump sum is paid. Instead, payments continue for life.

Children

- Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.

Compensation Rates

- For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children.

  Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 40% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule.

  Federal payments are made through Direct Deposit. Therefore, a, completed Form SF-1199A, Direct Deposit Sign-up must be submitted with Form CA-5.

  If the employee was covered under the Federal Employees' Retirement System (FERS), 5 USC 8116(d)(2) requires that Social Security benefits payable to beneficiaries, which are attributable to the deceased employee's Federal Service, are deducted from the beneficiary's compensation entitlement.

Funeral/Burial Allowance

- Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.

Third Party Action

- If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

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

Privacy Act Notice

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

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

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestion& for reducing this burden, to the Office of Workers' Compensation Programs, US Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

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

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

Official Superior's Report of Employee's Death

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

1. Name of Deceased Employee (Last, first. middle)	2. Date of Birth (Mo., day, year)	3. ☐ Male ☐ Female	4. Social Security No,

5. Department or Agency	6. OWCP Agency Code	7. OSHA Site Code

8. Name and Address of Reporting Office	9. Name and Office Phone Number of Employee's Official Superior

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

13. Describe how injury occurred	14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ No (if No, explain) :

15. Location where Injury occurred	16. Location where death occurred	17. Immediate cause of death (Attach medical and autopsy report if available)

18. Employee's pay rate as of	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of injury	$ per	$ per	S per	$ per
B. Date pay stopped	$ per	S per	S per	S per

19. Did employee work in positron held at time of injury for a full eleven months immediately prior to the injury? yes ☐ No	20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? Yes No

21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) From To	22. a. Occupation code b. Type code / c. Source code OWCP use - NOI code
23. Did employee receive continuation of pay (COP) during perrod pnor to death? a. Pay rate used for COP $ per / b. Inclusive dates of cop From To	24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number:

25. Show date through which HBS deductions were last made (Mo., day, year)	26. Identify employee's Federal Retirement Plan: ☐ CSBS ☐ FERS ☐ Other _____	27. If employee received medical care prior to death, give name and address of attending physician

28. If injury was caused by a third party, give name and address of third party	29. Give name and address of the attorney representing the survivors if legal action is instituted against the third party	**30. Show amount of third party recovery, if any** $

31. If employee was a member of the Armed Services the United States show: Branch of Service: Serial No. (If known)	32. Has claim for survivor's benefits been filed with the Office of Personnel Management? ☐ Yes ☐ No

33. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)

34. Signature of Official Superior	35. Title	36. Date (Mo., day, year)

Instructions for Completing Form CA-6

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

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

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

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

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

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

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

OWCP Agency Code

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

Instructions Form CA-7B
Leave Buy Back Worksheet

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

Things to Know About Leave Buy Back:

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

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

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

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

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

Instructions to the Employee:

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

1. Complete the Form CA-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete Form CA-7a following the instructions for completing that form.

2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.

3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, arid the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.

    a. If the total amount of FECA benefits estimated by the agency is not more than 1 0% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.

    b. If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Off ice will offer you a new election with the correct amount of FECA benefits payable,

II. Agency Certification:

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

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

J. Balance Due Agency from Employee *(Line H minus Line I)* 13. $ _____

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

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

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

_____ _____

(Signature of Agency Official) (Title/Position)

Phone No _____ Date Signed: _____

Employing Agency Address for Check: _____

_____

_____

III. Employee Claim:

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

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

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

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

_____ _____

(Signature of Claimant) (Date Signed)

Leave Buy Back (LBB) Worksheet/ Certification and Election

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

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

A. Name of Employee: *(Last, First, Middle)*	B. OWCP File Number:
C. Social Security Number:	

D. Period for Which Compensation is Claimed to Repurchase Leave

From: _____ / _____ / _____ To: _____ / _____ / _____

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate *(excluding overtime)*

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

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

_____ / _____ / _____
(effective date)

B. Additions to Base Pay:
If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ÷ by 52.

- Night Differential 2. _____
- Sunday Premium 3. _____
- Subsistence/Quarters 4. _____
- Other *(Specify)* 5. _____

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

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

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

F. Total Hours Worked per Week 9. _____

G. Formula ***(for FECA Entitlement)***

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

Form CA 7b
June 1996

Instructions for Completing Form CA-7A
Time Analysis

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

Instructions for Employee:

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

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

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

Block 6:

1st Column:	Show full date.
2nd Column:	For each date noted in column 1, state "Y" if you are claiming compensation for that date and "N" if you are not.
3rd, 4th, 5th and 6th Columns:	Show the number of hours of LWOP, number of hours worked, paid holiday hours, and number of hours of paid leave.
7th Column:	Using the legend provided, indicate the type of leave used.
8th Column:	State the reason you were off work. For each date for which compensation is claimed, there must be medical evidence supporting entitlement.

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

Instructions for Employing Agency:

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

Time Analysis Form

Reset **Print**

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

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

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

4. Period Covered by This Form:
From: To:

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

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

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

Signature of Claimant _____ Date Signed _____

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

Signature of Agency Official _____ Date Signed _____

Form CA 7a
June 1996

Instructions to the Agency:

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

Section I. Agency Estimate of FECA Entitlement:

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

For unusual situations, please refer to Payrate Desk Aid.

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

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

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

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

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

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

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

> *Example of computation:* The weekly pay from line 6 is $574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:
>
> $574.00 x 3/4 x 82 hours ÷ 40 hours = $882.52

Section II. Agency Certification:

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

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

Section III. Employee Claim:

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

What A Federal Employee Should Do When Injured At Work

Report to Supervisor

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

Obtain Medical Care

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

File Written Notice

In traumatic injuries, complete the employee's portion of Form CA-1. Obtain the form from your employing agency, complete and turn it in to your supervisor as soon as possible, but not later than 30 days following the injury. For occupational disease, use form CA-2 instead of form CA-1. For more detailed information carefully read the "Benefits ..." and "Instructions ..." sheets which are attached to the Forms CA-1 and CA-2.

Obtain Receipt of Notice

A "Receipt" of Notice of Injury is attached to each Form CA-1 and Form CA-2. Your supervisor should complete the receipt and return it to you for your personal records. If it is not returned to you, ask your supervisor for it.

Submit Claim For COP/Leave and/or Compensation For Wage Loss

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

The Federal Employees' Compensation Act (FECA) is administered by the U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs (OWCP). Benefits include continuation of pay for traumatic injuries, compensation for wage loss, medical care and other assistance for job-related injury or death. For additional information about the FECA, read pamphlet CA-11, "When Injured at Work" or Federal Personnel Manual, Chapter 810, Injury Compensation, available from your employing agency. The agency will also give you the address of the OWCP Office which services your area.

Post on Employees' Bulletin Board

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

U.S. GOVERNMENT PRINTING OFFICE: 1991 0-866-435

Form CA-10
Rev. Aug. 1987

Claim for Continuance of Compensation Under the Federal Employees' Compensation Act

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

INSTRUCTIONS TO BENEFICIARIES

OMB No. 1215-0154
Expires: 06-30-08

1. It is important that you carefully complete the other side of this form and return it to the OWCP within 30 days. Your failure to do so will result in suspension of the compensation you are receiving.
2. Complete Section A by printing the full name of the deceased employee and the OFFICE OF WORKERS' COMPENSATION PROGRAMS file number.
3. Answer all questions in the section or sections that apply to you. If you are receiving compensation as the:
   (A) WIDOW OR WIDOWER Complete Section B.
   (B) WIDOW OR WIDOWER RECEIVING COMPENSATION ON HER OR HIS ACCOUNT AND ON ACCOUNT OF A MINOR CHILD OR CHILDREN - Complete Sections B and C.
   (C) GUARDIAN OR CUSTODIAN OF A MINOR CHILD OR GRANDCHILD OR A PERSON INCAPABLE OF SELF-SUPPORT - Complete Section C.
   (D) PARENT, GRANDPARENT, OR A PERSON WHO IS PHYSICALLY INCAPABLE OF SELF-SUPPORT - Complete Section D.
   (E) Complete Block C if dependent is receiving educational benefits.
4. Carefully read and comply with directions in Section E.
5. Complete and sign the certificate in Section F.
6. Please return the completed form, in an envelope, to the address shown below.

The information on this form will be used to determine your eligibility for continuing benefits. Your response to this information is required to retain your compensation benefits. (20 CFR 10.126)

RETURN TO: U.S. DEPARTMENT OF LABOR, DFEC
CENTRAL MAILROOM
P.O. BOX 8300
LONDON, KY 40742-8300

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is required by P.L. 103-296 108 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefits and payment files.)

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

Public Burden Statement

We estimate that it will take an average of 5 minutes per response to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the 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.

Reset Print

IMPORTANT: READ CAREFULLY THE INSTRUCTIONS ON THE OTHER SIDE OF THIS FORM BEFORE ANSWERING THE QUESTIONS BELOW

I HEREBY APPLY FOR CONTINUANCE OF COMPENSATION BENEFITS AWARDED TO ME (OR TO THE CLAIMANT ON WHOSE BEHALF I AM NOW ACTING) BY THE OFFICE OF WORKERS' COMPENSATION (OWCP) ON ACCOUNT OF THE DEATH OF: _____

A. Name of Deceased Employee	Employee's Federal Retirement Plan ☐ CSRS ☐ FERS ☐ Other	OWCP File No.

THIS BLOCK TO BE COMPLETED BY WIDOW/WIDOWER RECEIVING COMPENSATION

B. 1. Have You Married since the Death of Above Named Employee? ☐ Yes ☐ No (If "Yes" complete 10)

2. Do You Receive a Pension or Allowance from any other Federal Agency such as the Veterans' Administration, Social Security Administration or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

THIS BLOCK TO BE COMPLETED BY ANY PERSON RECEIVING COMPENSATION ON BEHALF OF CHILD GRANDCHILD, OR DEPENDENT INCAPABLE OF SELF-SUPPORT

C. 3. Have any Dependents You Claim Compensation for Married Since the Death of the Above Named Employee? ☐ Yes ☐ No (If "Yes" complete 10)

4. Do Any Dependents You Claim Compensation for Receive a Pension or Allowance from Any Other Federal Agency Such as the Veterans' Administration, Social Security Administration, or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

5. Give the Following Information for Each Person You Receive Compensation For:

NAME	AGE	IS PERSON IN YOUR CUSTODY? (Yes or No)	NAME, ADDRESS, AND RELATIONSHIP OF PERSON(S) HAVING CUSTODY IF NOT IN YOUR CUSTODY

THIS BLOCK IS TO BE COMPLETED BY PARENT, GRANDPARENT, OR DEPENDENT PHYSICALLY INCAPABLE OF SELF-SUPPORT

D. 6. Have You Married Since the Death of the Above Named Employee'? ☐ Yes ☐ No (If "Yes" complete 10)

7. Do You Receive a Pension or Allowance from any other Federal Agency such as the Veterans' Administration or the Civil Service Commission on Account of the Death of this Employee? ☐ Yes ☐ No (If "Yes" complete 11)

8. Are You Capable of Self-Support? ☐ Yes ☐ No

9. Have You Been Employed Since Filing Your Last Claim Form? ☐ Yes ☐ No (If "Yes" complete 12)

ADDITIONAL INFORMATION: THIS BLOCK TO BE COMPLETED ONLY WHEN AN ANSWER TO 1, 2, 3, 4, 5, 6, 7, or 9 IS "YES."

E. 10. When and Where was the Marriage Performed and What was the Change in Name, If Any?

11. What Agency is Paying the Benefits and For What Reason Are They Being Paid?

12. State the Name of Your Employer, Nature of Employment, Dates Employed, and Amount Earned.

(Space for Answers to questions 10, 11, and 12)

CLAIMANT'S CERTIFICATION - TO BE COMPLETED IN ALL INSTANCES

F. I DECLARE UNDER THE PENALTIES OF PERJURY THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT: AND THAT I WILL IMMEDIATELY NOTIFY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS OF ANY CHANGES IN STATUS.

Signature of Claimant (or guardian)	Date (month, day, year)
Address of Claimant (or guardian)	Telephone Where You Can Be Reached
Signature of Witness and Date Witnessed if Claimant Signs by Mark (X)	

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

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

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

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

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

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

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

Attending Physician's Report

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

OMB No. 1215-0103
Expires: 10-31-08

Record of Examinaton

1. Patient's name * Last First Middle
2. Date of Injury * mo, day yr
3. OWCP File Number *
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? * f 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
Specialty
Address
27. What was the reason for this referral?
City State ZIP
☐ 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 statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.
Signature of Physician Signature * Date
29. Name of Physician *
30. Tax ID Number *
Address *
31. Do you specialize? * ☐ Yes ☐ No
City * State ZIP
32. If yes, indicate specialty

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

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

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

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

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

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

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

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

Duty Status Report

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

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

OMB No. 1215-0103
Expires: 10-31-08

OWCP File Number (If known)

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

1. Employee's Name (Last, first, middle)
2. Date of Injury (Month, day, yr.)
3. Social Security No.
4. Occupation
5. Describe How the Injury Occurred and State Parts of the Body Affected
6. The Employee Works
   Hours Per Day ____ Days Per Week ____
7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or intermittently, and Give Number of Hours.

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

t. Other (Describe)

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)
9. Description of Clinical Findings
10. Diagnosis Due to Injury
11. Other Disabling Conditions
12. Employee Advised to Resume Work?
    ☐ Yes, Date Advised ____ ☐ No
13. Employee Able to Perform Regular Work Described on Side A?
    ☐ Yes, If so ☐ Full-Time or ☐ Part-Time ____ Hrs Per Day
    ☐ No, If not, complete below:

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

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)
15. Date of Examination
16. Date of Next Appointment
17. Specialty
18. Tax Identification Number
19. Physician's Signature
20. Date

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 verity statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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

STATEMENT BY EMPLOYING ORGANIZATION: We hereby certify that the officer who executed the foregoing claim for compensation was injured while in performance of duty under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. All statements made in this claim are true to the best of our knowledge and belief.	16. Signature	17. Date Signed
	18. Title	

ATTENDING PHYSICIAN'S MEDICAL REPORT

1. I certify that the above-named officer has been under my professional care for the following period for the effects of this injury.

FROM THROUGH

2. History of Injury

3. Findings	4. Diagnosis
5. Type and Frequency of Treatment	6. Type of Further Treatment Recommended
7. In Your Opinion, Was Disability A Result of the Injury as Reported in item 2? ☐ Yes ☐ No If No, State Your Reason For Believing Disability Resulted From Other Causes	8. Anticipated Permanent Effects
	9. Other Complicating or Concurrent Diseases or Disabilities Not Due to This Injury

10. As A Result of This Injury, Officer Was Confined to (show dates): Hospital Bed Rest at Home Home	11. Dates Officer Totally Disabled For All Work	12. Date Officer May be Able to Resume Light Work
	13. Dates Officer Partially Disabled For Usual Occupation	14. Date Officer May be Able to Resume Regular Work

15. I certify that the answers to the above questions are true to the best of my knowledge and belief. I am licensed to practice medicine and surgery in the state of	16. Signature	17. Date Signed
	18. Mailing Address Including ZIP Code	

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Claim for Compensation

1. Last, First, Middle Name of Injured Officer	2. Date of Injury (month, day, year)
3. Name of Employing Organization	4. Period Compensation is Claimed as a Result of Pay Loss: From Through
5. Has Any Pay Been Claimed or Received for the Period Shown in Item 4? ☐ Yes ☐ No If Yes, State Amount and List Dates	6. Was Subsistence or Quarters Furnished During Period Shown in Item 4? ☐ Yes ☐ No If Yes, State Which and Show Value and inclusive Period

7. Did Officer Work For Any Other Employer During Period Shown in Item 4? ☐ Yes ☐ No If Yes, Furnish →	A. Name and Address of Employer	B. Amount Earned	C. Period Worked: From Through

8. Has Claim Been Made Against Any Third Party For Damages on Account of This Injury? ☐ Yes ☐ No if Yes, Furnish →	A. Name and Address of Party	B. Amount of Recovery Received

9. Was Officer Ever in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, Furnish →	A. Service Number	B. Branch of Service	C. Period of Service From Through

10. If Question 9 is Answered "Yess" Has Application Ever Been Made for Compensation or Pension, Including Retirement or Retainer Pay, on Account of Such Service? ☐ Yes ☐ No If Yes, Furnish →	A. Claim Number	B. Name and Address of Office Where Claim is Filed	C. Nature of Disability and Amount of Monthly Payment

11. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States ? ☐ Yes ☐ No If Yes, Furnish	A. Type of Annuity (e.g., civil service retirement)	B. Claim Number

12. Has Application Been Made For Compensation, Annuity, or Other Benefits as a Result of This Injury Under Any Compensation Law, Police Disability Compensation Fund, or Other Such Fund? ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.	13. If Married, Give Date of Officer's Marriage

14. List Officer's Dependents. If None. So State

Name	Relation - ship to Officer	Date Of Birth	Living With Officer?	If Not, Show Mailing Address
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	
			☐ ☐	

15. For Dependents Not Living With Officer, Show Amounts That He Pays for Their Support, to Whom Paid, and Payee's Address. State Whether Such Payments Were Ordered by A Court.

Employing Organization's Report

1. Name and Mailing Address Including ZIP Code of Employing Organization

2. Name of Injury Officer's Immediate Superior

3. Name and Telephone Number of Person to Contact

4. Last, First, Middle Name of Injury Officer

5. Officer's Birth Date (month, day, year)

6. Social Security Number

7. Date Employing Organization First Received Injury Notice
Date: ☐ Verbal ☐ Written

8. Name of Person to Whom Notice Was First Given

9. Date and Hour of Injury ☐☐ am/pm

10. Date and Hour Stopped Work ☐☐ am/pm

11. Date and Hour Pay Stopped ☐☐ am/pm/

12. Date and Hour Returned to Work ☐☐ am/pm

13. Will Officer Receive Pay For Any Portion of Absence From Work Because of the Injury?
☐ Yes ☐ No
If Yes, Furnish →

A. Types(s) of Leave

B. Amount Paid

C. Dates For Which Leave Paid

14. Rate of Pay on Date of injury

Base $ Per

Subsistence, If Extra $ Per

Quarter, If Extra $ Per

15. List and Show Value of Other Pay Increments on Date of Injury

$ Per

$ Per

16. On Day of Injury Officer's Shift →
a. Began ☐ am/☐ pm
b. Ended ☐ am/☐ pm

17. Number of Hours Worked Per Day (exclusive of overtime)

18. Circle Days Normally Worked Per Week (exclusive of overtime) SU MO TU WE TH FR SA

19. Did Officer Work for the Organization a Full 11 Months Immediately Prior to Injury?
☐ Yes ☐ No

20. If No, Would His Job Have Afforded Employment For 11 Months Except For the Injury?
☐ Yes ☐ No

21. Was Officer Performing Regular Duties When Injured? ☐ Yes ☐ No
If No, Give Full Explanation

22. Was the Injury Caused By:
a. Officer's Willful Misconduct? ☐ Yes ☐ No
b. Officer's Intoxication? ☐ Yes ☐ No
c. Officer's Intent to Bring About Injury to Self or Another (other than normally required in performance of duty)? ☐ Yes ☐ No
Attach Detailed Explanation for Any "Yes" Answers

23. If Known, Give Name and Address of Suspect(s) or Witness(es) With Whom Officer Was Involved When Injured.

24. Describe Fully How the Officer's Injury Occurred While Enforcing the Laws of the United States. If possible, give U.S. Code Citation.

25. Give Comments Regarding Completeness and Validity of the Facts Provided by Officer (attach detailed explanation if there is disagreement).

26. Signature	27. Title	28. Date Signed

The Office of Workers' Compensation Programs requires this claim before compensation can be awarded to an officer for pay loss, permanent disability, or when the Officer is unable to resume his regular work. The officer completes items 1 through 15 and gives it to the officer's employing organization which will certify as to the validity of the information contained in the claim by completing items 17, 18, and 19. If it does not agree that all answers are correct, it should attach a detailed statement giving the reason for its disagreement. If pay loss is involved, this claim should not be completed until 14 calendar days have elapsed since the beginning of the pay loss, or until the officer has returned to work, whichever occurs first.

7. ATTENDING PHYSICIAN'S MEDICAL REPORT. If the CLAIM FOR COMPENSATION is completed, this report is to be completed by the physician supervising medical treatment. It is not necessary if the CLAIM FOR COMPENSATION is not completed.

8. SUBMITTING THIS FORM. This form should be turned over to the employing organization. The organization will have any remaining parts completed. Afterwards, it should review the form for completeness and to see that all signatures appear. If a report of investigation of any type was made on the injury or the incident leading to injury, a copy should be attached. When the form and any statements and attachments are ready for transmission, this instruction page should be removed. Only one copy of this form (the original) need be submitted.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 522a), 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.

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

All completed forms, documents, and inquiries should be sent to
Office of Workers' Compensation Programs
Washington, D.C. 20211

Notice of Law Enforcement Officer's Injury Or Occupational Disease

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

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

OMB No. 1215-0116
Expires: 08-31-2007

Statement of Injured Officer

1. Last, First, Middle Name of Injured Officer

2. Date of Injury (month, day, year)

3. Hour of Injury
☐ am ☐ pm

4. Location Where Injury Occurred (number, street, building, city, state)

5. Nature of Injury (e.g., fractured left leg)

6. Did Injury Cause Permanent Disability? ☐ Yes ☐ No
If Yes, Describe

7. Described Fully Why and How Injury Occurred

I certify that the injury described above was sustained in performance of official duty and occurred in such a manner as to entitle me to **benefits under 5 U.S.C. 8101 et seq. as extended by 5 U.S.C. 8191. I hereby make** claim for compensation and medical treatment **to which I may be entitled by reason of this** injury.

8. Signature

9. Date Signed

10. Mailing Address Including ZIP Code

Statement of Witness

1. Describe What You Saw, Heard or Know About This Injury

2. Signature

3. Date Signed

Medical Report by Physician who First Attended Injured Officer

1. Date of First Visit (month, day, year)

2. Nature of Injury

3. Dates of Hospitalization

4. Name and Mailing Address of Hospital

5. Type and Frequency of Treatment

6. In Your Opinion Was Disability A Result of the Injury Described In Item 7. Of the Statement of the Injured Officer?
☐ Yes ☐ No If No, State Your Reason for Believing Officer's Disability Resulted from Other Circumstances

7. Type of Further Treatment Recommended

8. Signature

10. Date Signed

9. Mailing Address Including ZIP Code

INSTRUCTIONS FOR COMPLETING THIS FORM

(Please do not detach)

1. GENERAL. This form is used to report an injury or occupational disease sustained by a non-Federal law enforcement officer under circumstances involving a crime against the United States. Specifically, section 8191 of title 5, United States Code, provides Federal workmen's compensation benefits for a person determined to have been on any given occasion-

(1) a law enforcement officer and to have been engaged on that occasion in the apprehension or attempted apprehension of any person-

(A) for the commission of a crime against the United States, or

(B) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(C) who at that time was sought as a material witness in a criminal proceeding instituted by the United States: or

(2) a law enforcement officer and to have been engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime; or

(3) a law enforcement officer and to have been engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States;

and to have sustained a personal injury (including disease) related to that occasion. Federal law enforcement officers are excluded from section 8191.

If one of the above conditions is met, this form should be filed with the Office of Workers' Compensation Programs if the injured officer-

(1) is disabled and is in a, non-pay status for more than 3 calendar days;

(2) has permanent disability;

(3) is unable to resume his regular work;

(4) incurs unpaid medical expenses; or

(5) if there is a likelihood that disability or unpaid medical expenses will subsequently occur.

The form is designed so that the CLAIM FOR COMPENSATION page may be detached if the claim is not needed. However, read paragraph 6 below thoroughly before detaching the claim page.

If additional space is needed for any answer, attach a separate sheet of paper and write, "see separate sheet," in the appropriate box of this form. Please place the name of the injured officer (and, case file number if known) on any separate sheets. This form must be filed with OWCP within 5 years from the date of injury.

2. STATEMENT OF INJURED OFFICER. This statement must be completed in all instances and only by-

(1) the injured officer, preferably

(2) a member of his immediate family;

(3) his guardian, personal representative, or other person legally authorized to act on his behalf; or

(4) any association of law enforcement officers acting on his behalf.

3. STATEMENT OF WITNESS. This statement normally is used if the injury was not reported at the time that it occurred or if some fact is not clear. It is not necessary if a report of investigation is submitted.

4. MEDICAL REPORT BY PHYSICIAN WHO FIRST ATTENDED INJURED OFFICER. This report is not necessary if a more complete medical report on this form or on another form or in narrative is being submitted.

5. EMPLOYING ORGANIZATION'S REPORT. This report must be completed in every instance. Wage information, duty hours, and like information should be obtained from the organization's records. The organization must review the injured officer's statement and the circumstances of the injury, and in item 25 should comment concerning the completeness and validity of the officer's statement, If the organization disagrees with the officer's statement, it should submit a detailed explanation giving the reasons for its disagreement.

6. CLAIM FOR COMPENSATION. This claim must be completed in every instance where the injured officer-

(1) is disabled and is in a non-pay status for more than 3 calendar days;

(2) has permanent disability; or

(3) is unable to resume his regular work.

It need not be submitted where claim is made only for medical expenses, or if there is only a likelihood that disability or medical expense subsequently will occur.

Claim on Behalf of Widow, Widower, or Children

1. Last, First, Middle Name of Deceased Officer	2. Date of Death (month, day, year)
3. Mailing Address Including ZIP Code of Surviving Spouse or Guardian	4. Nature of Injury Which Caused Death
5. Name of Officer's Former Employing Organization	

CLAIM OF SURVIVING SPOUSE	6. Date of Marriage to Officer	7. Was Spouse Living With Officer at Time of Death? ☐ Yes ☐ No	8. Number of Children Now Living Who Are the Issue of This Marriage
	9. Was Spouse Married at Any Time to Anyone Other Than Officer? ☐ Yes ☐ No	10. Was the Officer Married at Any Time to Anyone Else? ☐ Yes ☐ No	11. Date of Birth of Surviving Spouse

If answer to either items 9 or 10 is yes, submit documents to show dissolution of prior marriages, such as death certificates, divorce decrees.

12. List all Children of the Officer for Whom Claim is Being Made (those living at the time of his death and who were under 18, or who were over 18 and a student or incapable of self-support)

Name	Date of Birth	Living at Address Shown in Item 3?	If Not, Show Mailing Address
		☐ ☐	
		☐ ☐	
		☐ ☐	
		☐ ☐	

13. Has a Legal Guardian Been Appointed for Any of the Above-Named Children? ☐ Yes ☐ No If Yes, Give Name and Mailing Address of Guardian of Each Child and Attach a Certified Copy of Appointment Documents

14. List Any Other Relatives Who May be Entitled to Compensation

Name	Date of Birth	Mailing Address	Relationship to Officer

15. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.

16. Was Officer Ever in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, Furnish →	A. Service Number	B. Branch of Service	C. Period of Service From / Through
17. If Question 16 is Answered "Yes," Has Application Ever Been Made for Compensation or Pension on Account of Such Service? ☐ Yes ☐ No If Yes, Furnish →	A. Claim Number	B. Name and Address of Office Where Claim is Filed	
18. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States? ☐ Yes ☐ No If Yes, Furnish →	A. Type of Annuity (e.g., civil service retirement)	B. Claim Number	

19. I hereby make claim for compensation for the spouse and/or children listed above, under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191, as a result of the death of the above-named officer, who sustained fatal injury while in the performance of duty. Every statement set forth above is true to the best of my knowledge and belief.

(Signature of Claimant) (Date)

The form and the attachments (please read paragraph 6 below) should be sent to the officer's former employing organization.

6. ATTACHMENT. There are several documents that must be submitted in support of most claims. Sometimes they will not be readily available. To avoid delays in processing this form, make up a list of those documents that will be sent at a later date. Then as documents are received send them directly to the Office of Workers' Compensation Programs.

Needed are:

(1) Officer's death certificate (all cases);

(2) Birth certificates of all children claiming compensation; for adopted children furnish orders of adoption instead of birth certificates.

(3) Marriage certificate of spouse claiming compensation:

(4) Documents showing dissolution of prior marriages of officer and of spouse, such as final divorce decrees, death certificates (needed only if spouse is claiming compensation);

(5) Officer's birth certificate (needed only if claim is being made by parent, grandparent, brother, or sister of officer);

(6) Dependent's birth certificate (needed only if claim is being made by brother, sister, or grandchild of officer);

(7) As proof of relationship to the officer a grandparent claiming compensation must provide the birth certificate of the officer's mother or father, as appropriate; a grandchild claiming compensation must provide the birth certificate of the officer's son or daughter, as appropriate;

(8) A recent medical report describing disability for unmarried dependents over age 18 who are basing their claim on mental or physical disability (needed only if claim is being made by widower, child, brother, sister, or grandchild); if this person is committed to a public institution merely state the name and address of the institution.

Except for (8), all documents must bear the signature and seal (imprint) of the public official having custody of such records. All documents or records originating in a court of law must bear the signature and seal (imprint) of the proper court official. Photostat copies are not acceptable unless they bear the actual signature and seal of the public official, not just a copy.

7. SUBMITTING THIS FORM. This form and available attachments should be turned over to the officer's former employing organization. The organization will have any remaining parts completed. Afterwards, it should review the form and attachments for completeness and to see that all signatures appear. If a report of investigation of any type was made on the death or the incident leading to death, a copy should be attached. When the form and any statements and attachments are ready for transmission, this instruction page should be removed. Only one copy of this form (the original) need be submitted.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 522a), 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 claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, DC. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

All completed forms, documents, and inquiries should be sent to
Office of Workers' Compensation Programs
Washington, D.C. 20211

INSTRUCTIONS FOR COMPLETING THIS FORM

(Please do not detach)

1. GENERAL. This form is used to report a death sustained by a non-Federal law enforcement officer under circumstances involving a crime against the United States. Specifically, section 8191 of title 5, United States Code, provides Federal workmen's compensation benefits for a person determined to have been on any given occasion -

(1) a law enforcement officer and to have been engaged on that occasion in the apprehension or attempted apprehension of any person

(A) for the commission of a crime against the United States, or

(B) who at that time was sought by a law enforcement authority of the United States for the commission of a crime against the United States, or

(C) who at that time was sought as a material witness in a criminal proceeding instituted by the United States; or

(2) a law enforcement officer and to have been engaged on that occasion in protecting or guarding a person held for the commission of a crime against the United States or as a material witness in connection with such a crime; or

(3) a law enforcement officer and to have been engaged on that occasion in the lawful prevention of, or lawful attempt to prevent, the commission of a crime against the United States;

and to have sustained a personal injury (including disease) resulting in death, related to that occasion. Federal law enforcement officers are excluded from section 8191.

If one of the above conditions is met, this form should be filed with the Office of Workers' Compensation Programs if there are survivors eligible for benefits or if there are any unpaid medical, funeral, or transportation bills. The form is designed so that if there are no eligible survivors who wish to file claim, then their portion of the form may be detached.

If additional space is needed for any answer, attach a separate sheet of paper and write, "see separate sheet," in the appropriate box of this form. Please place the name of the deceased officer (and case file number if known) to OWCP within 5 years from the date of death. If there are no survivors, it is suggested that their portion of this form be completed before the former employing organization and the physician complete their portion.

2. EMPLOYING ORGANIZATION'S REPORT. This report must be completed in every instance by the deceased officer's former employing organization. Wage information, duty hours, and like information should be obtained from the organization's records. If the organization disagrees with one or more of the statements made by the survivors, it should submit a detailed explanation giving the reasons for its disagreement.

3. ATTENDING PHYSICIAN'S MEDICAL REPORT. This report is to be completed by a physician who examined or treated the deceased officer. It is not necessary if a copy of a more complete medical report is being submitted.

4. CLAIM ON BEHALF OF WIDOW, WIDOWER, OR CHILDREN. This is a formal claim for death benefits on behalf of all those listed in the claim, it may be submitted by -

(1) any survivor of the deceased officer;

(2) any guardian, personal representative, or other person legally authorized to act on behalf of the officer's estate or any of his survivors; or

(3) any association of law enforcement officers acting on behalf of the officer's survivors.

Items 6 through 11 on this claim pertain to the surviving spouse and should not be completed if no claim is being made on his or her behalf, or if there is no surviving spouse. Item 12 asks for names of surviving children. If there are more children than room to enter their names, attach a separate sheet. This is very important. In the last line of item 12 write, "see attached sheet for names of additional children."

In item 14 list anyone else for whom the officer was furnishing some support at the time of his/her death. Include minor children from his/her prior marriages even though the officer was not supporting them prior to his/her death. Again, if more room is needed attach a separate sheet.

The form and the attachments (please read paragraph 6 below) should be sent to the officer's former employing organization.

5. CLAIM ON BEHALF OF DEPENDENT OTHER THAN WIDOW WIDOWER, OR CHILDREN. This is a formal claim for death benefits on behalf of one person. If more than one person listed below was dependent on the deceased officer, write to the Office of Workers' Compensation Programs for extra forms. This claim may be submitted by -

(1) any survivor of the deceased officer;

(2) any authorized to act on behalf of the officer's estate or any of his survivors; or

(3) any association of law enforcement officers acting on behalf of the officer's survivors. Those dependents other than the widow, widower, and children who may be eligible for benefits include dependent parents, dependent grandparents, dependent brothers, dependent sisters, and dependent grandchildren of the officer. There is no provision in the law for other relatives.

24. Define, Explain, or Identify the Circumstances of This Injury Resulting in Death Which Involves the United States (see the first paragraph of the instruction sheet attached to this form).

We hereby certify that the officer, whose death is reported above, was injured while in performance of duty under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191. All statements made in this report are true to the best of our knowledge and belief.	25. Signature	26. Date Signed
	27. Title	

IMPORTANT: Please attach a copy of any investigation report of this injury and death. If no report was made, a statement from each witness should be attached reporting what he saw, heard, or knows about the incident leading to injury and death.

ATTENDING PHYSICIAN'S MEDICAL REPORT

1. Last, First, Middle Name of Deceased Officer	2. Date of Death (month, day, year)
3. History of Injury	
4. If Death Was Not Instantaneous, Describe Treatment Provided	5. Inclusive Dates on Which Treatment Was Given
6. Direct Cause of Death	
7. Contributory Cause of Death	

8. In Your Opinion, Was Death of the Officer Due to the Injury as Reported in Item 3? ☐ Yes ☐ No If No, State Your Reasons For Believing Death Resulted From Other Causes.

9. Was a Biopsy or Autopsy Performed? ☐ Yes ☐ No If So, By Whom?

10. I certify that the answers to the above questions are true to the best of my knowledge and belief. I am licensed to practice medicine and surgery in the state of	11. Signature	12. Date Signed
	13. Mailing Address Including ZIP Code	

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3229, 200 Constitution Avenue, N.W., Washington, DC. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Notice of Law Enforcement Officer's Death

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

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

OMB No. 1215-0116
Expires: 08-31-2007

EMPLOYING ORGANIZATION'S REPORT

1. Name and Mailing Address Including ZIP Code of Employing Organization

2. Name of Deceased Officer's Immediate Superior

3. Name and Telephone Number of Person to Contact

4. Last, First, Middle Name of Deceased Officer

5. Officer's Birth Date (month, day, year)

6. Social Security Number

7. Officer's Last Mailing Address Including ZIP Code

8. Date and Hour of Injury am/pm

9. Date of Death

10. Date and Hour Pay Stopped am/pm

11. Rate of Pay on Date of Injury

Base $ Per
Subsistence, If Extra $ Per
Quarters, If Extra $ Per

12. List and Show Value of Other Pay Increments on Date of injury

$ Per
$ Per

13. On Day of Injury Officer's Shift → a. Began am/pm b. Ended am/pm

14. Number of Hours Worked Per Day (exclusive of overtime)

15. Circle Days Normally Worked Per Week (exclusive of overtime) SU MO TU WE TH FR SA

16. Did Officer Work for the Organization a Full 11 Months Immediately Prior to Injury? ☐ Yes ☐ No

17. If No, Would His Job Have Afforded Employment For 11 Months Except For the Injury? ☐ Yes ☐ No

18. Describe Nature of Injury Which Caused Death

19. Describe Fully How the Officer's Death Occurred While Enforcing the Laws of the United States. If possible, give the U.S. Code Citation.

20. Was Officer Performing Regular Duties When Injured? If No, Give Full Explanation ☐ Yes ☐ No

21. Was the Injury Caused By:

a. Officer's Willful Misconduct? ☐ Yes ☐ No
b. Officer's intoxication? ☐ Yes ☐ No
c. Officer's Intent to Bring About Injury to Self or Another (other than normally required in performance of duty)? ☐ Yes ☐ No

Attach Detailed Explanation for Any "Yes" Answers

22. If Known, Give Name and Address of Suspect(s) or Witness(es) With Whom Officer Was Involved When Injured

23. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? ☐ Yes ☐ No

If Yes, Give Name and Address of Organization With Which Application Was Filed.

Claim on Behalf of Dependent Other Than Widow, Dependent Widower, or Children

1. Last, First, Middle Name of Deceased Officer

2. Date of Death (month, day, year)

3. Name of Officer's Former Employing Organization

4. Nature of Injury Which Caused Death

5. Last, First, Middle Name of Dependent

6. Dependent's Mailing Address Including ZIP Code

7. Dependent's Birth Date

8. Dependent's Social Security Number

9. Relationship to Officer

10. Dependency on Officer ☐ Total ☐ Partial

11. Amount Contributed by Officer Toward Dependent's Support During the 12 Months Immediately Prior to Death

12. Did Officer Live With Dependent During the 12 Months Immediately Prior to Officer's Death? ☐ Yes ☐ No If Yes, Furnish →

A. Amount Paid by Officer to Dependent in Money or Service for Room and Board in Addition to Contribution Shown in Item 11.

B. If No Fixed Amount Was Paid for Room and Board, What is the Fair Value of Such Room and Board?

13. Was Dependent Employed During the 12 Months Immediately Prior to Officer's Death? ☐ Yes ☐ No If Yes, Furnish →

A. Occupation (s)

B. Period Employed

C. Monthly Rate of Pay

14. In Addition to Employment, State Other Income From All Sources During the 12 Months Prior to Officer's Death.

Investments $ | Pensions $ | From People Other Than Officer $ | All Other Sources $

15. At Time of Officer's Death Was Dependent Married? ☐ Yes ☐ No If Yes, Furnish →

A. Birth Date

B. Occupation

C. Total Income From All Sources For 12 Months Prior to Officer's Death

D. Monthly Rate of Pay

16. List All Property Owned by Dependent and/or Spouse (omit clothing, furniture). Give Approximate Market Value of Each Item and Date Acquired

17. List Name and Relationship of Persons Dependent Upon This Dependent.

18. Has Application Been Made for Compensation, Annuity, or Other Benefits as a Result of This Death Under Any Compensation Law, Police Death or Survivor's Benefit Fund, or Other Such Fund? ☐ Yes ☐ No If Yes, Give Name and Address of Organization With Which Application Was Filed.

19. Was Officer Ever in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, Furnish →

A. Service Number

B. Branch of Service

C. Period of Service From

Through

20. Has Application Ever Been Made for Any Annuity on Account of Officer's Civilian Service With the United States? ☐ Yes ☐ No If Yes, Furnish →

A. Type of Annuity (e.g., civil service retirement)

B. Claim Number

21. I hereby make claim for compensation under 5 U.S.C. 8101 et seq., as extended by 5 U.S.C. 8191, as a result of the death of the above-named officer, who sustained fatal injury while in performance of duty. Every statement set forth above is true to the best of my knowledge and belief.

(Signature of Claimant) (Date)

Appendix B: SMIS Quick Reference

Quick Reference for SMIS Accident Reporting – DOI Employees Module

Accessing SMIS Accident Reporting

1. Open your browser and in the Address field, type **http://www.smis.doi.gov**.
2. Click **Accident Reporting**.
3. Click **DOI Employees**.

Logging In

4. From the main "Safety Management Information System" screen, click **DOI Employees**.
5. In the **Last Name** field, type your last name.
6. In the **SSN Last-4** field, type the last four digits of your social security number.
7. Press **Enter** or click **Employee Login**.
8. What you do next depends on whether you are initiating a new claim OR completing or reviewing an existing claim.

   If you are initiating a new claim, in the **Enter your Internet E-Mail Address** field, type your email address and click **Verify E-mail and Request a Claim ID**. If an email address already displays in the **Enter your Internet E-Mail Address** field, verify that it is correct and click **Verify E-mail and Request a Claim ID**.

   - If you are completing or reviewing an **existing claim**, type your claim ID in the **Enter your claim ID** field and click **Send Claim ID - Enter your Claim**.

Initiating an Injury Report (Claim)

Once you have your claim ID, you can file a CA-1 or CA-2 form online.

9. In the **Enter your Claim ID** field, type the claim ID that you received in an email.
10. Click **Send Claim ID - Enter your Claim** to proceed completing a CA-1 or CA-2 form.
11. In the **5. Home telephone** box, type your home telephone number.
12. Verify that the mailing address in the **7. Employee's home mailing address** (including city, state, and zip code) box is correct. Change the information as required.
13. Identify all your dependents.
14. Select the type of report you are filing:
    - (CA-1) Injury/Traumatic Injury
    - (CA-2) Occupational Disease/Illness
15. Click **Proceed to Description of your Injury/Illness**.

Printing a Completed CA-1 or CA-2 Form

16. Open the claim you want to print and click **Print CA-1 Form** or **Print CA-2 Form**, depending on the type of report you have completed. (You cannot change any information from this view.)
17. From the **File** menu, select **Print**. The form prints exactly as it appears on screen.

Viewing the Status of Your Claim

18. Open the claim you want to view.
19. Click **Claim Status** at the top of the screen to view the status of your claim. The "Status of Claim for Compensation filed by <Claimant Name>" screen is displayed.

Completing the CA-1 Form

In the Description of Injury section of the screen…

20. In the **9. Place Where Injury Occurred** box, type a detailed description of the location at which you injured yourself. Be specific.
21. In the **10. Date Injury Occurred** box, type the date on which the accident occurred (mm/dd/yy, mm/dd/yyyy, or dd/mm/yyyy).
22. In the **Time** box, select the time at which the accident occurred.
23. In the **12. Employee's Occupation** box, type your job title. If a job title already appears in this field, you cannot change it.
24. In the **13. Cause of Injury** box, describe, in detail, how and why the accident occurred.
25. In the **14. Nature of Injury** box, describe your injury.

In the Employee Certification section of the screen…

26. In **box 15**, determine how you wish to receive payment by selecting **Continuation of regular pay (COP)** or **Sick and/or Annual Leave**.
27. Check the **I have read and understand the above statement** box.

28. Click **Complete your Claim Submission** to file your claim.
29. Notify your supervisor that you have completed a CA-1 form:
    - In the **Enter Your Supervisor's Email Address** field, type his or her email address and click **Send Email to your Supervisor**.
    - If you do not know your supervisor's email address, type his or her name in the **Enter Your Supervisor's Name** field and click **Prepare Paper Notification**.

Completing the CA-2 Form

In the Claim Information section of the screen…

30. In the **9. Employee's Occupation** box, type your job title. If a job title already appears in this field, you cannot change it.
31. In the **10. Location (address) where you worked when disease or illness occurred** box, type the street address, city, state, and zip code of the location where you first became ill.
32. In the **11. Date you first became aware of disease or illness** box, type the date on which you first noticed you were ill (mm/dd/yy, mm/dd/yyyy, or dd/mm/yyyy).
33. In the **12. Date you first realized the disease or illness was caused or aggravated by your employment** box, type the date on which you first realized you were ill because of your job with the U.S. government (mm/dd/yy, mm/dd/yyyy, or dd/mm/yyyy).
34. In the **13. Explain the relationship to your employment and why you came to this realization** box, describe why you believe your disease or illness is job-related.
35. In the **14. Nature of Disease or Illness** box, describe your disease or illness and how it has affected your body.
36. In the **15. If this notice and claim was not filed with the employing agency within 30 days after the date you realized the disease was related to your employment, explain the reason for the delay** box, describe why you delayed completing this form. If you are completing this form within 30 days of becoming ill, leave this field blank.
37. In the **16. If the required employee statement is not included in this report, explain the reason for the delay** box, describe why you might be delayed in getting your statement within 30 days of your claim being processed.
38. In the **17. If the required medical reports are not submitted with this report, explain the reason for the delay** box, describe why you might be delayed in getting this report within 30 days of your claim being processed.

In the Employee Certification section of the screen…

39. In box 18, check the I have read and understand the above statement checkbox.
40. Click **Complete your Claim Submission** to file your claim.
41. Notify your supervisor that you have completed a CA-2 form:
    - In the **Enter Your Supervisor's Email Address** field, type his or her email address and click **Send Email to your Supervisor**.
    - If you do not know your supervisor's email address, type his or her name in the **Enter Your Supervisor's Name** field and click **Prepare Paper Notification**.

Quick Reference for SMIS Accident Reporting – Comp Coordinators Module

Accessing SMIS Accident Reporting

1. Open your browser and in the Address field, type **http://www.smis.doi.gov**.
2. Click Accident Reporting.
3. Click Comp Coordinators.

Logging into the Comp Coordinators Module

4. From the "Safety Management Information System" screen, click **Comp Coordinators**.
5. In the **User ID** field, type your user ID.
6. In the **Password** field, type your password and press **Enter** or click **Login to SMIS as Compensation Coordinator**.
7. If you are logging into Comp Coordinators for the first time, type your email address. Press **Enter** or click **Submit/Verify your E-mail Address to confirm your email address**.

Accessing Pending Claims

There are two ways to access pending claims.

8. Click the hyperlink of the claim you want to review. The claim form is displayed, or
9. If you know a user's claim ID, enter it in the **Enter the Claimant's Claim ID here:** field below the list of displayed claims.
10. Click **View this Claim**. The claim form is displayed.

Printing a Claim Form

11. Access the claim you want to print.
12. Click the **Print Comp Form** option at the top of the screen to view the CA-1 or CA-2 form.
13. From the **File** menu, select **Print** to print the form.
14. Have the claimant and the claimant's supervisor sign and date the printed form and return it to you. A copy of the form should be retained on file by the claimant filing the claim, the claimant's supervisor, and you, the compensation coordinator.

Viewing the Employee Section of Accident Reports

15. Access the claim for which you want to view the Employee section.
16. Click the **Employee Section** button at the top of the screen.
17. Click **Exit Employee Section** when you are done reviewing the claimant's accident report.

Viewing and Modifying the Supervisor Section of Accident Reports

18. If you do not want to process a compensation claim, place a checkbox in the **The Agency is challenging the claim, additional info will follow under separate cover** box.
19. In the **Local Case Notes: (Enter any information you would like to convey to the compensation coordinator*)** box, review any notes about the accident that the supervisor entered for you to read.
20. Do one of the following:
    - Click **Submit Supervisor Report Changes** when you are done reviewing and/or making changes to the supervisor's section.
    - Click **Exit Supervisor Section** if you did not make any changes.

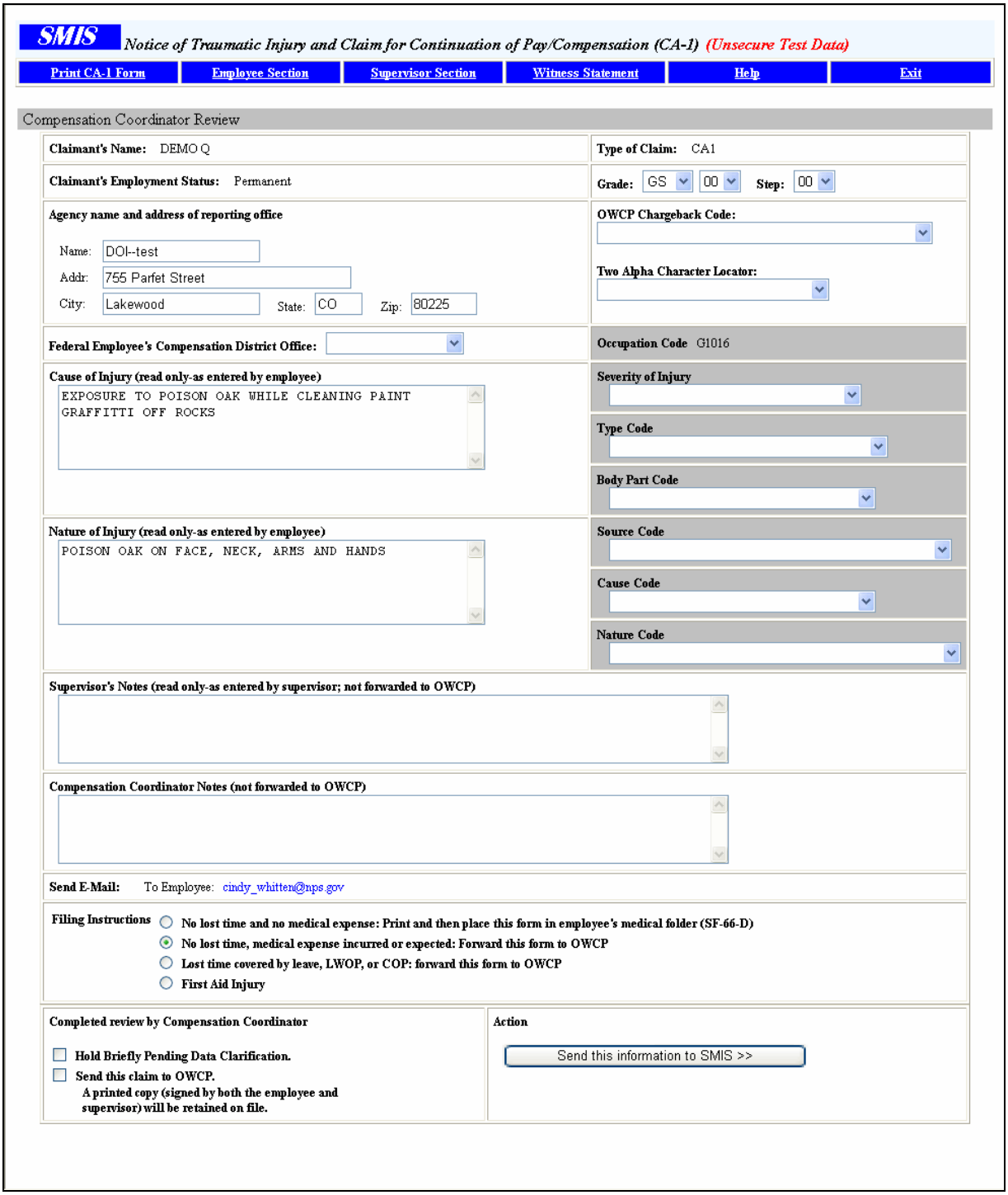
Updating and Reviewing a Compensation Claim

21. Access the claim you want to update, review, and process.
22. From the **Federal Employee's Compensation District Office** drop-down list, select the district in which the claimant's office is assigned.
23. From the **OWCP Chargeback Code** drop-down list, select the code that represents the claimant's agency site responsible for paying the worker's compensation claim.
24. From the **Two Alpha Character Locator** drop-down list, select the locator code that represents the location in which the claimant works.
25. From the **Severity of Injury** drop-down list, select the option that best describes

the type of medical treatment required because of the claimant's injury.

26. From the **Type Code** drop-down list, select the option that best describes how the claimant was injured.
27. From the **Body Part Code** drop-down list, select the option that best describes the part of the body that the claimant injured.
28. From the **Source Code** drop-down list, select the option that best describes the item or environment that caused the claimant's injury.
29. From the **Cause Code** drop-down list, select the option that best describes what instigated the claimant's accident.
30. From the **Nature Code** drop-down list, select the option that best describes the nature or severity of the claimant's injury.
31. Review comments from the claimant in the **Relationship of Condition to Work (read only-as entered by employee)** and **Nature of Injury (read only-as entered by employee)** boxes.
32. Review any comments from the supervisor in the **Supervisor's Notes (read only-as entered by supervisor; not forwarded to OWCP)** box. Notes in this box are not forwarded to OWCP, but remain as part of the completed claim form.
33. In the **Compensation Coordinator Notes (not forwarded to OWCP)** box, type any comments you want to add regarding the claim. These notes are not forwarded on to OWCP, but remain as part of the completed claim form.
34. If you are processing a CA-1 claim, in box **39. Filing Instructions**, select how you want to file the claim.
35. Place a check in the appropriate **Completed review by Compensation Coordinator** checkboxes to complete the review of and process the pending claim. You can select **Hold Briefly Pending Data Clarification** or **Send this claim to OWCP**.
36. Click **Send this information to SMIS**. Within 48 hours of processing a claim, OWCP will email you and the claimant an OWCP claim number.
37. Click **Print the Claim for Compensation** to print the claim form. Remember that you must have the claimant and claimant's supervisor sign the compensation claim form.

Figure 1. SMIS CA-1 Screen.



Appendix C: OWCP Contacts

Department of Labor District Offices

(Map adapted from DOL materials.)

District Office 1--Boston
(CT, ME, MA, NH, RI, and VT)
Alonzo Rodriquez, District Director
U. S. Dept. of Labor, OWCP
JFK Federal Building, Room E-260
Boston, MA 02203
617-624-6600, 617-624-6618(Fax)

District Office 2--New York
(NJ, NY, PR, and the Virgin Islands)
Zev Sapir, District Director
U. S. Dept. of Labor, OWCP
201 Varick Street, Room 740
New York, NY 10014
DFEC: 646-264-3000, World Trade Center cases:
646-264-3030, DFEC Fax: 646-264-3006
Longshore: 646-264-3010
Longshore Fax: 646-264-3002

District Office 3--Philadelphia
(DE, PA, and WV; MD when the claimant's residence has a zip code beginning 21)
John McKenna, District Director
U. S. Dept. of Labor, OWCP
Curtis Center, Suite 715 East
170 S. Independence Mall West
Philadelphia, PA 19106-3308
215-861-5481 or 5482, 215-861-5453(Fax)

District Office 6--Jacksonville
(AL, FL, GA, KY, MS, NC, SC, and TN)
Magdalena Fernandez, District Director
U. S. Dept. of Labor, OWCP
400 West Bay Street, Room 826
Jacksonville, FL 32202
904-357-4777 or 4778, 904-357-4773 (Fax)

District Office 9--Cleveland
(IN, MI, OH; all special claims, all U.S. possessions, and territories/trust territories)
Robert Sullivan, District Director
U. S. Dept. of Labor, OWCP
1240 East Ninth Street, Room 851
Cleveland, OH 44199
216-357-5100 , 216-357-5378 (Fax)

District Office 10--Chicago
(Illinois, Minnesota, Wisconsin)
Joan Rosel, District Director
U. S. Dept. of Labor, OWCP
230 South Dearborn Street, Eighth Floor
Chicago, IL 60604
312-596-7157, 312-596-7145 (Fax)

District Office 11--Kansas City
(IA, KS, MO, and NE; all employees of the Department of Labor, except Job Corps enrollees, and their relatives)
Lois Maxwell, District Director
U. S. Dept. of Labor, OWCP, City Center Square
1100 Main Street, Suite 750
Kansas City, MO 64105
816-502-0301, 816-502-0314 (General Fax)

District Office 12--Denver
(CO, MT, ND, SD, UT, and WY)
Shirley Bridge, District Director
U. S. Dept. of Labor, OWCP
1999 Broadway, Suite 600
Denver, CO 80202
720-264-3000, 720-264-3124 (Fax)

District Office 13--San Francisco
(AZ, CA, HI, and NV)
Andy Tharp, District Director
U. S. Dept. of Labor, OWCP
90 Seventh St., Suite 15300
San Francisco, CA 94103 ,
or write to: P.O. Box 193769
San Francisco, CA 94119-3769
415-625-7500 , 415-625-7450 (Fax)
Please note new District Office Address, Phone Number, and Fax number effective 3/12/07.

District Office 14--Seattle
(AK, ID, OR, and WA)
Marcus Tapia, District Director
U. S. Dept. of Labor, OWCP
1111 Third Avenue, Suite 650
Seattle, WA 98101-3212
206-398-8100, 206-398-8151 (Fax)

District Office 16--Dallas
(AR, LA, NM, OK, and TX)
Frances Memmolo, District Director
U. S. Dept. of Labor, OWCP
525 South Griffin Street, Room 100
Dallas, TX 75202
972-850-2300, 972-850-2301 (Fax)

District Office 25--Washington, D. C.
(DC, VA; MD when the claimant's residence has a zip code beginning other than 21***)
Linda DeCarlo, District Director
U. S. Dept. of Labor, OWCP
800 N. Capitol Street, N.W., Room 800
Washington, D.C. 20211
202-513-6800 (D.C., Maryland and Virginia)
202-513-6806 (Fax)

Appendix D: Adjudication & Case Status Codes

Table 3. **List of Codes in Agency Query System (AQS)**

CASE STATUS CODES	
UN	Case created, and should not be changed unless the case has been reviewed by a claims examiner, or a bill for treatment authorized by Form CA-16 has been filed. UN changed to any status generates "review date"
UD	Under development. Used whenever further development is needed before pay status or closure status can be assigned. Assigned without an adjudication code, after initial review if there is not enough evidence for acceptance or denial. Assigned with "DO" if a case in D status is remanded for development by ECAB or Hearings and Review, or is under reconsideration
MC	Entitled for time being to medical treatment only.
DR	Entitled to payment on daily roll. Used for finite period of wage loss or repurchase of leave; not used for schedule award paid in lump sum or for initial or final supplemental payments where the case is or will be on the periodic roll.
PR	Entitled to payment on periodic roll; re-employment or earning capacity not yet determined.
PS	Entitled to payment for schedule award, whether periodic or lump sum.
PN	Entitled to payment on periodic roll; formally determined to have no wage earning capacity or re-employment potential for indefinite future.
PW	Entitled to reduced compensation reflecting partial wage earning capacity or actual earnings.
DE	Monthly payments are being made to at least one beneficiary of a deceased federal employee.
ON	Overpayment exists; final decision made on issues of fault and waiver. Claimant not on periodic roll.
OP	Overpayment exists; final decision made on issues of fault and waiver. Claimant on periodic roll.
C1	Closed. Accepted. No further payments anticipated. No time lost from work.
C2	Closed. Accepted. No further payments anticipated. Time lost covered by leave. Leave not repurchased.
C3	Closed. Benefits denied.
C4	Closed, entitlement to continuation of pay accepted. Pay was continued for time lost from work. No further payments anticipated.
C5	Closed. Previously accepted for benefits. All benefits paid.
CL	Administrative closure.
RT	Retired or waiting for retirement.
XX	Awaits destruction.

APPROVALS	
AM	Condition accepted as compensable. If open, entitlement to medical benefits only.
AL	Condition accepted and some period of disability supported by medical evidence. Leave elected or used awaiting adjudication.
AC	Condition accepted as compensable. Some period of entitlement to continuation of pay accepted.
AD	Condition accepted as compensable. Some period of entitlement to compensation is/was accepted. Not on periodic roll.
AP	Condition accepted as compensable. Claimant was or is entitled to compensation on the periodic roll.
AF	Death accepted as work related. Some beneficiary is or was entitled to benefits.
AT	Condition accepted as work related but claimant entitled only to medical benefits.
AO	Case previously approved. No benefits payable. May be used to identify a case with a third party credit being absorbed.

DENIALS	
DO	Disallowed pending
D1	Denied as not timely filed.
D2	Denied. Claimant not a civil employee.
D3	Denied. Fact of injury not established.
D4	Denied. Not in the performance of duty.
D5	Denied. Causal relationship not established or disability due to injury has ceased
D7	Remanded by ECAB.
D8	Remanded by Branch of Hearings and Review.
D9	Request for reconsideration pending.
SU	Consideration for benefits suspended for failure to report for an Office directed medical examination.

VOCATIONAL REHABILITATION	
1	Closed: from referral
2	Closed: rehabilitation with new employer
3	Returned to work: assisted reemployment program.
4	Closed: rehabilitated (previous employer)
5	Closed: Other.
6	Closed: after post employment services
7	Returned to work: Nurse Intervention Program
8	Return to work: No OWCP Assistance.
9	Return to work: claims examiner assistance.
A	Initial interview held
B	Nurse intervention program
C	Return to claims examiner
D	Plan development
E	Employed
F	Working part-time or temporary
G	Assisted re-employment program
H	Employed by nurse
I	Plan approved
J	Short-term assisted re-employment
K	No return to work: work tolerance limits obtained.
L	Nurse: working part time or light duty.
M	Medical rehabilitation
N	Placement: previous employer without other services
O	No return to work: no work tolerance limitations obtained
P	Placement with new employer
Q	Screened
R	Early referral
S	Self-employed

Voc. Rehab Codes continued.	
T	Training
V	Employee assistance program: rehabilitation counselor follow-up
W	Placement: Previous employer with other services
X	Services interrupted
Y	Nurse Interrupted
Z	Post Employment Services

RELATIONSHIP CODES	
AR	OWCP Accounts Receivable for repayment.
B	Injured worker's brother.
CP	Case Payee (such as the employing agency)
CL	Claimant (Injured worker)
D	Injured worker's daughter.
F	Injured worker's father.
FE	Social Security Administration for FERS Offset
GC	Injured worker's grandchild.
GP	Injured worker's grandparent.
GR	Injured worker's guardian.
LB	Employing agency for Leave Buy Back.
LE	Payment Offset for law enforcement officer.
M	Injured worker's mother.
SI	Injured worker's sister
SO	Injured worker's son.
W	Injured worker's widow.
WR	Injured worker's widower.

DECISION CODES	
A1/A2	Claim certified for payment.
B1/B2	Claim denied for payment. A decision has been sent.
C1/C2	Claim period already covered by compensation on periodic roll every 28 days.
D1/D2	Form CA-1207 has been sent showing the amount of leave buy back payable. Form must be completed and returned to OWCP before compensation can be paid.
E1/E2	Claimed period can not be paid because there is no lost wages. Possible reasons include dates of COP, paid leave, etc.
F1/F2	Duplicate period claimed. Compensation already paid.
G1/G2	Claim can not be paid. Possible reasons include an incomplete form, receipt of retirement benefits for the same period, etc.
H1/H2	Schedule award paid for permanent impairment.
I1/I2	Claim paid for recurrence of disability.
X1/X2	Claim received prior to acceptance of injury. Compensation paid.
Y1/Y2	Claim can not be paid. Possible reasons include those stated in B, C, E, F and G above.

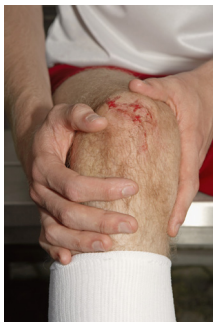
DECISION CODES	
30	Claim can not be paid until additional medical evidence is received.
31	Claim can not be paid until a decision has been reached on acceptance of claim.
32	Claim can not be paid until the case file is returned to the District Office.
33	Claim can not be paid until the employer provides additional information.
34	Claim can not be paid until the injured worker elects between OWCP compensation and benefits from another federal program.
35	Claim for schedule award can not be paid until additional medical evidence is received on the level of permanent impairment.
36	Claim could not be paid at the time of review for reasons other than those stated above.
37	Claim can not be paid until a decision is reached on acceptance of recurrence of disability.
38	Claim for leave buy back can not be paid until additional information is received.

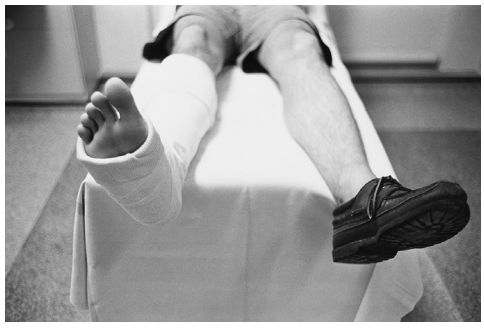
Appendix E: Disability Matrix

Table 4. OWCP Length of Disability Matrix

Condition	Accepted Length of Disability
Inguinal hernia	6 weeks with surgery, none otherwise
Other, multiple, and ill-defined dislocations (subluxation)	8 weeks
Sprains/strains of shoulder and upper arm	3 weeks
Sprains/strains of the wrist	3 weeks
Sprains/strains of knee and leg	3 weeks
Sprains/strains of ankle	6 weeks with conservative therapy. 12 weeks with surgery
Sprains/strains of foot	3 weeks
Sprains/strains, sacroiliac region	8 weeks
Sprains/strains, lumbosacral region	8 weeks
Sprains/strains of other and unspecified parts of back	8 weeks
Sprains/strains, neck	8 weeks
Sprains/strains, thoracic	8 weeks
Sprains/strains, lumbar	8 weeks
Sprains/strains, back (not otherwise specified)	8 weeks
Open wound, hand	4 weeks
Open wound, fingers	4 weeks
Superficial injury, cornea	2 days
Contusion of face, scalp, and neck except eye(s)	2 weeks
Contusion of back	2 weeks
Contusion of upper limb	2 weeks
Contusion of elbow/forearm	2 weeks
Contusion of finger	2 weeks
Contusion of lower limb and of other and unspecified sites	2 weeks
Contusion of foot	2 weeks
Foreign body in external eye	2 days







Appendix F: Occupational Disease Checklists

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

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

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

FROM EMPLOYEE	✓	FROM EMPLOYING AGENCY	✓
1. Prepare a statement giving the following information:		1. Review the employee's statement, giving the following information:	
a. Provide an outline of your work history, including non-Federal employment and military service. For each job held, give your job title, agency/company name, and dates (period) of employment.		a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.	
b. For each job title, describe duties which required exertion with or repeated movement of the wrist or hand. Describe nature and frequency of motions required, and average number of hours a day/week you did such work.		b. Provide a day-to-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.	
c. Describe hobbies, physical fitness or other activities outside of work which also involved exertion or repeated motions of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.		c. Give date employee entered on duty in job requiring above duties. Also give the effective date(s) and description(s) of any changes in work assignments due to employee's condition and indicate whether duty changes resulted in changes in pay.	
d. If you have ever had an injury to the hand/arm/wrist, or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist, from/since birth, describe the injury or condition, and state when injury occurred or condition was found.		2. Send us copies of employee's:	
e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected, when you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.		a. SF-1 71, Application for Employment;	
2. Ask all doctors who treated you to send us a copy of reports or notes describing the condition, testing, and treatment given.		b. Position description with physical requirements for last job held;	
		c. All available medical records, including report of pre-employment examination;	
		d. SF-50s or equivalent documents for changes in assignment/pay due to condition.	

3. Ask the doctor currently treating your condition to provide a detailed current medical report to include the following specifics:

a. Dates of examinations;

b. Complete medical history of condition;

c. Medical diagnosis of condition;

d. Findings and test results, specifically including: results of Phalen's and Tinel's Sign tests: physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence; results of nerve conduction velocity, and electromyographic testing;

e. Treatment to date and prognosis;

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

It is MOST IMPORTANT that the doctor provide opinion as to the likely nature of the physical effects attributable to specified duties of your Federal job, and explain the medical reasoning which supports the opinion as to cause.

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

Form CA-35H
October 1987

Evidence Required in Support of a Claim for Occupational Disease

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

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

FROM EMPLOYEE	✓
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job actions.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.	

FROM EMPLOYING AGENCY	✓
5. Review and comment on employee's statement provided in response to Item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

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

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

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

FROM EMPLOYEE	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.	
2. For each job title, describe source of noise, number of hours of exposure per day, and use of any safety devices to protect against noise exposure. State when safety devices were provided.	
3. Give history of any previous ear or hearing problems.	
4. Describe any hobbies which involve exposure to loud noise.	
5. If you are no longer exposed to hazardous noise at work, give the date you were last exposed.	
6. If you have been examined or treated by a doctor for an ear or hearing problem, provide a medical report and audiograms.	
7. State whether a claim for workers, compensation benefits for this or any other condition affecting ears or hearing was ever filed. If so, give date of claim, name and address where filed, and benefits received.	
8. Give the date you first noticed your hearing loss.	
Give date you first related hearing loss to employment, and reason why.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the employee's statement in response to questions 1-5.	
10. Describe all work-related exposure to hazardous noise, including: a. Locations of job sites. b. Nature of exposure to noise (machinery, etc.). c. Decibel and frequency level (noise survey report) for each job site. d. Period of exposure, hours per day, days per week. e. Type of ear protection provided.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Job sheet and employment record. c. All medical examinations pertaining to hearing or ear problems, including preemployment examination and all audiograms.	
12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

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

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

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

FROM EMPLOYEE	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service **(see attached questionnaire.)**	
2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days per week exposed, and the types and frequency of safety precautions (mask, respirator, etc.) used **(see attached questionnaire).**	
3. Describe any exposure you have had to other toxic substances. If none, state "None".	
4. Describe any breathing or lung problems you have had in the past and treatment received **(see attached questionnaire)**.	
5. Give your smoking history to include amount per day, and years (dates) you have smoked **(see attached questionnaire)**.	
6. Submit a report from your physician, including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.	
7. Give the date you first consulted a physician regarding respiratory or asbestos-related disease.	
8. Submit reports of examination, treatment or hospitalization for any previous similar condition or pulmonary problem.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
10. Provide exposure data, including air sample surveys or statements of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fiber/cc time weighted average. Also report concentrations of other pollutants and chemicals **(see attached questionnaire)**.	
11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
12. Attach copies of the employee's: a. SF-1 71, Application for Employment. b. Position description with physical requirements for last job hold. c. Job shoot and employment record. d. Pertinent dispensary records. e. Most recent SF-50, Notification of Personnel Action. f. Laboratory test results and chest x-ray reports on file.	
13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

PART A TO BE COMPLETED BY CLAIMANT

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

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

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

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

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

Heavy - Visible airborne asbestos particles were evident.

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

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

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

b. Toxic Chemicals/Dust

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

(PLEASE CONTINUE ON REVERSE SIDE)

Notice to Employees Filing Claim for Occupational Disease

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

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

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

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

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

Notice to Compensation Specialists and Supervisors

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

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

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

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

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

We appreciate your cooperation in this effort.

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

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

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

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

PART B TO BE COMPLETED BY EMPLOYING AGENCY

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

a. Nature of Exposure:

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

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

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

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

b. Degree of Exposure:

Heavy - Asbestos dust was usually visible in the air.

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

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

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

c. Frequency of Exposure: Hours per day.

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

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

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

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

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

FROM EMPLOYEE	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
5. Provide a medical report from your physician which includes: a. Dates of examination and treatment. b. History given by you. c. Family history and other risk factors. d. Detailed description of findings. e. Copies of all diagnostic test results. f. Diagnosis. g. The clinical course of treatment followed. h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements in response to questions 1-5.	
7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

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

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

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

FROM EMPLOYEE	✓
1. Give a detailed description of employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.	
3. Describe any previous skin conditions from the time they began through the present.	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions.	
5. Attach or forward a medical report from your current physician to include: a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in Item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure. g. Work restrictions caused by the condition.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements provided in response to questions 1-5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Copies of all physical examinations on file. e. Most recent SF-50, Notification of Personnel Action.	

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

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

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

FROM EMPLOYEE	✓
1. Describe the work conditions which caused or aggravated your pulmonary condition; include types of irritants, dates of exposure and hours per day. Describe any safety measures taken.	
2. Explain the development of the present pulmonary condition and treatment from its beginning.	
3. Give your smoking history to include amounts and years (dates) you smoked.	
4. Give the history of previous pulmonary conditions: include dates and nature of illness, and treatment records from all physicians and hospitals where you were treated.	
5. Attach or forward a medical report which includes the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may have and the factors of employment listed in Item no. 1.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on employee's statement provided in response to questions 1-5. Give periods, degree and nature of exposure. Explain safety precautions. Give full details of any tests which were made to determine the concentration of irritants. Have other employees been similarly affected?	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination and any other pertinent medical records. d. Most recent SF-50, Notification of Personnel Action.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

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

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

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

FROM EMPLOYEE	✓
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2. Describe the progress and development of the work-related condition from its beginning.	
3. Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✓
7. Review and comment on the employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

MEDICAL REPORT FOR PSYCHIATRIC CLAIM

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

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

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

We appreciate your cooperation in this effort.

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

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

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

We appreciate your cooperation in this effort.

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

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

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

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

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

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

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

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

FORM SUBMISSION

FECA: Send all forms for FECA to the DFEC Central Mailroom, P.O. Box 8300, London, KY 40742, unless otherwise instructed.
BLBA: Send all forms for BLBA to the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828, unless otherwise instructed.
EEOICPA: Send all forms for EEOICPA to the Energy Employees Occupational Illness Compensation Program, P.O. Box 727, Lanham-Seabrook, MD 20703-0727, unless otherwise instructed.

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

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

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

REFERS TO GOVERNMENT PROGRAMS ONLY

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

BLACK LUNG, FECA AND EEOICPA CLAIMS

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

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

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

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

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

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, BLACK LUNG AND EEOICPA INFORMATION

(PRIVACY ACT STATEMENT)

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

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

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

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

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

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

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

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

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

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

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

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

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

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

Reset Print

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (INCLUDE AREA CODE)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

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

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

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

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Instructions (Form OWCP-957)

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

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

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

Please explain the following:

a. Relationship to the claimant

b. The reason you are requesting reimbursement

---

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

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

a. Enter date of travel.

b. Mark one box only.

c. Mark one box only.

d. Mark one box only.

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

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

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

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

8. The person claiming reimbursement must sign here.

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

FOR BLACK LUNG USE ONLY

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

FOR ENERGY EMPLOYEES ONLY

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

Public Burden Statement

We estimate that it will take an average of 10 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Office of Workers' Compensation, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

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

Medical Travel Refund Request

Reset Print

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

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

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

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

2. Case/Claim Number:

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

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

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

5a. Date of Travel:

b. ☐ One-way ☐ Round Trip

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

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

e. Medical facility name and address

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

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

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

6a. Date of Travel:

b. ☐ One-way ☐ **Round Trip**

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

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

e. Medical facility name and address

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

g. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

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

7a. Date of Travel:

b. ☐ One-way ☐ Round Trip

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

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

e. Medical facility name and address

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

9. Private Auto Only Miles traveled

DOL USE ONLY
TOS/Procedure Code $
Total $

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

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

Claimant's/Payee's Signature: Date:

INSTRUCTIONS FOR USE OF FORM OWCP-915

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

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed OWCP-915

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

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

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

Medical Expense other than prescription medication

1. Completed OWCP-915

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

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

Travel

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

Public Burden Statement

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

Claim for Medical Reimbursement

Reset Print

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

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

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

PERSONAL INFORMATION

Name

Last | First | M.I.

OWCP File Number

Address

Street/P.O. Box/Apt No.

City | State | Zip Code

Telephone Number

FOR DOL USE ONLY

PROVIDER INFORMATION

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

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

Total Reimbursement
$

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

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

Signature _____ Date _____

Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary condition). Coding structure must follow the International Classification of Disease, 9th Edition, Clinical Modification or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.

Item 22. Leave blank.

Item 23. Leave blank.

Item 24. Column A: enter month, day and year (MM/DD/YY) for each service/consultation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in Column G.
Column B: enter the correct CMS/OWCP standard "place of service" (POS) code (see below).
Column C: not required.
Column D: enter the proper five-digit CPT (current edition) code and modifier(s), the HCPCS, or the OWCP generic procedure code.
Column E: enter the diagnostic reference number (1, 2, 3 or 4 in Item 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.
Column F: enter the total charge(s) for each listed service(s).
Column G: enter the number of services/units provided for period listed in Column A. Anesthesiologists enter time in total minutes, not units.
Column H: leave blank.
Column I: leave blank.
Column J: leave blank.
Column K: leave blank.

Item 25: Enter the Federal tax I.D.

Item 26: Provider may enter a patient account number that will appear on the remittance voucher.

Item 27: Leave blank.

Item 28: Enter the total charge for the listed services in Column F.

Item 29: If any payment has been made, enter that amount here.

Item 30: Enter the balance now due.

Item 31: Sign and date the form. Signature stamp or "signature on file" is acceptable.

Item 32: Enter complete name of hospital, facility or physician's office were services were rendered.

Item 33: Enter (1) the name and address to which payment is to be made, and (2) your DOL provider number after "PIN #" if you are an individual provider, or after "GRP #" if you are a group provider. FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE A REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.

Public Burden Statement

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

Place of Service (POS) Codes for Item 24B

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

Appendix G: Injury-Illness Source/Type Codes

INJURY/ILLNESS TYPE CODES

100 STRUCK
110 Struck by
111 Struck by falling object
120 Struck against

200 FELL, SLIPPED, TRIPPED
210 Fell on same level
220 Fell on different level
230 Slipped, tripped (no fall)

300 CAUGHT
310 Caught on
320 Caught in
330 Caught between

400 PUNCTURED, LACERATED
410 Punctured by
420 Cut by
430 Stung by
440 Bitten by

500 CONTACT
510 Contact with (motion of person)
520 Contact by (motion of object)

600 EXERTION
610 Lifted, strained by (single action)
620 Stressed by (repeated action)

700 EXPOSURE
710 Inhalation
720 Ingestion
730 Absorption

800 TRAVELING IN

999 UNCLASSIFIED OR INSUFFICIENT DATA

INJURY/ILLNESS SOURCE CODES

0100 BUILDING OR WORKING AREA
0110 Walking/working surface (floor, street, curbs, porches)
0120 Stairs, steps
0130 Ladder
0140 Furniture, furnishings, office equipment
0150 Boiler, pressure vessel
0160 Equipment layout (ergonomic)
0170 Windows, doors
0180 Electric, electricity

0200 ENVIRONMENTAL CONDITION
0210 Temperature extreme (indoor)
0220 Weather (ice, rain, heat, etc.)
0230 Fire, flame, smoke (not tobacco)
0240 Noise
0250 Radiation
0260 Light
0270 Ventilation
0271 Tobacco smoke
0280 Stress (emotional)
0290 Confined space

0300 MACHINE OR TOOL
0310 Hand tool (powered: saw, grinder, etc.)
0320 Hand tool (non-powered)
0330 Mechanical power transmission apparatus
0340 Guard, shield (fixed, moveable, deadman)
0350 Video Display Terminal
0360 Pump, compressor, air pressure tool
0370 Heating equipment
0380 Welding equipment

0400 VEHICLE
0410 Privately-owned vehicle (includes rental)
0411 As driver
0412 As passenger
0420 Government-owned vehicle
0421 As driver
0422 As passenger
0430 Common carrier (airline, bus, etc.)
0440 Aircraft (not commercially scheduled)
0450 Boat, ship, barge

0500 MATERIAL HANDLING EQUIPMENT
0510 Earthmover (tractor, backhoe, etc.)
0520 Conveyor (for material and equipment)
0530 Elevator, escalator, personnel hoist
0540 Hoist, sling chain, jack (for material and equipment)
0550 Forklift, crane
0560 Handtrucks, dollies

0600 DUST, MIST, VAPOR, ETC.
0610 Dust (silica, coal, grain, cotton)
0620 Fibers
0621 Asbestos
0630 Gases
0631 Carbon monoxide
0640 Mist, steam, vapor, fume
0650 Particles (unidentified)

0700 CHEMICAL, PLASTIC, ETC.
0710 Chemical dry
0711 Corrosive
0712 Toxic
0713 Explosive
0714 Flammable
0720 Chemical liquid
0721 Corrosive
0722 Toxic
0723 Explosive
0724 Flammable
0730 Plastic
0740 Water
0750 Medicine

0800 INANIMATE OBJECT
0810 Box, barrel, container, etc.
0820 Paper
0830 Metal item, mineral
0831 Needle
0840 Glass
0850 Scrap, trash
0860 Wood
0870 Food
0880 Personal clothing, apparel, shoes

0900 ANIMATE OBJECT
0910 Animal
0911 Bite (dog)
0912 Bite (other)
0920 Plant
0930 Insect
0940 Human (violence)
0950 Human (communicable disease)
0960 Bacteria, virus (not human contact)

1000 PERSONAL PROTECTIVE EQUIPMENT
1010 Protective clothing, shoes, glasses/goggles
1020 Respirator, mask
1021 Diving equipment
1030 Safety belt, harness
1040 Parachute

9999 UNCLASSIFIED OR INSUFFICIENT DATA

Note: Select most specific type and source for event which initiated injury/illness.
Use heading as "other" for that category.
Use TYPE as "verb" and SOURCE as "noun" to describe incident.
EXAMPLE: Employee slipped on ice, cut hand on rock.
TYPE: 210, fell on same level
SOURCE: 0220, weather