Claim for Compensation

# U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

**SECTION 1** **EMPLOYEE PORTION**

a. Name of Employee Last First Middle

OMB No. 1215-0103
Expires: 08/31/2005

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

c. OWCP File Number

E-Mail Address *(Optional)*

d. Date of Injury
Month Day Year

e. Social Security Number

f. Telephone No./FAX No.
( ) –
( ) –

**SECTION 2** Compensation is claimed for:

| | | Inclusive Date Range From | To | Intermittent? | |
|---|---|---|---|---|---|
| a. ☐ | Leave without pay | | | ☐ Yes ☐ No | *Go to Section 3* |
| b. ☐ | Leave buy back | | | ☐ Yes ☐ No | *Go to Section 3, and Complete Form CA-7b* |
| c. ☐ | Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type: | | | ☐ Yes ☐ No | *Go to Section 3* |
| d. ☐ | Schedule Award (*Go to Section 4)* | | | If intermittent, complete Form CA-7a, Time Analysis Sheet | |

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

☐ Yes Name and Address of Business:

☐ No *Go to Section 4*

Name Address City State ZIP Code

Dates Worked: Type of Work:

**SECTION 4** Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

**SECTION 5** List your dependents (including spouse):

| Name | Social Security # | Date of Birth | Relationship | Living with you? Yes | No |
|---|---|---|---|---|---|
| | | / / | | ☐ | ☐ |
| | | / / | | ☐ | ☐ |
| | | / / | | ☐ | ☐ |

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

a. Are you making support payments for a dependent shown above? ☐ Yes ☐ No If Yes, support payments are made to:

Name Address City State ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No If Yes, attach copy of court order.

**SECTION 6** a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

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

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

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

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

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

Employee's Signature _____ Date (*Mo., day, year*) _____

**Employing Agency Portion**
**For first CA-7 claim sent, complete sections 8 through 15.**
**For subsequent claims, complete sections 12 through 15 only.**

**SECTION 8**

| Show Pay Rate as of | Additional Pay | Additional Pay | Additional Pay |
|---|---|---|---|
| Date of Injury: Base Pay | Type _____ | Type _____ | Type _____ |
| Date: ___/___/___ $_____ per _____ | $ _____ per _____ | $ _____ per _____ | $ _____ per _____ |
| Grade:_____ Step: _____ | | | |
| Date Employee Stopped Work: | Type _____ | Type _____ | Type _____ |
| Date: ___/___/___ $_____ per _____ | $ _____ per _____ | $ _____ per _____ | $ _____ per _____ |
| Grade:_____ Step: _____ | | | |

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

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

**SECTION 9**

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

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

FOR EXAMPLE ONLY

| | S | M | T | W | TH | F | S |
|---|---|---|---|---|---|---|---|
| WEEK 1 From 5/14 to 5/20 | | 8 | 4 | 6 | (6) | | |
| WEEK 2 From 5/21 to 5/27 | | 8 | | 6 | 6 | | 4 |

| | S | M | T | W | TH | F | S |
|---|---|---|---|---|---|---|---|
| WEEK 1 From _____ to _____ | | | | | | | |
| WEEK 2 From _____ to _____ | | | | | | | |

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

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

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

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

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Use Insurance? ☐ No ☐ Yes Class_____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan_____ *(Specify CSRS, FERS, Other)*

**SECTION 11** Continuation of Pay (COP) Received (*Show inclusive dates*):

From ___/___/___ To ___/___/___

Intermittent? ☐ Yes — Complete Time Analysis Sheet, Form CA-7a ☐ No

**SECTION 12** Show pay status and inclusive dates for period(s) claimed:

| | | Intermittent? | |
|---|---|---|---|
| Sick Leave From | ___/___/___ To ___/___/___ | ☐ Yes | ☐ No |
| Annual Leave From | ___/___/___ To ___/___/___ | ☐ Yes | ☐ No |
| Leave without Pay From | ___/___/___ To ___/___/___ | ☐ Yes | ☐ No |
| Work From | ___/___/___ To ___/___/___ | ☐ Yes | ☐ No |

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

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

**SECTION 13** Did employee return to work? ☐ Yes ☐ No

If Yes, date ___/___/___

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain: _____

**SECTION 14** Remarks:

**SECTION 15** An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

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

Signature_____ (*Agency Official*) Title_____ Date___/___/___

Name of Agency _____

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

Name_____ Title_____

Telephone No.(___)_____-_____ Fax No. (___)_____ E-Mail Address_____

# INSTRUCTIONS FOR COMPLETING FORM CA-7

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

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

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

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

**SUPERVISOR** (or appropriate official in the employing agency) – Complete sections 8 through 15 as directed and promptly forward the form OWCP.

**EXPLANATIONS** – Some of the items on the form which may require further clarification are explained below:

| Section Number | Explanation |
|---|---|
| 2d. Schedule Award | Schedule awards are paid for permanent impairment to a member or function of the body. |
| 5. List your dependents | Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-lime student; or 3) is incapable of self-support due to physical or mental disability. |
| 6a. Was/will there be a claim made against 3rd party? | A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury. |
| 8. Additional Pay | "Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. It the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported. |
| 11. Continuation of pay (COP) received | If the injury was not a traumatic injury reported on Form CA-1, this item does not apply. |
| 14. Remarks | This space is used to provide relevant information which is not present elsewhere on the form. |

**Pubic Burden Statement**

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

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

**DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

## FORM CA-20, PHYSICIAN'S REPORT

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

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

## PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to 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.**

Attending Physician's Report

# U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

**Record of Examinaton**

| 1. Patient's name Last | First | Middle | 2. Date of Injury mo. day yr. | 3. OWCP File Number | OMB No. 1215-0103 Expires: 08-31-05 |
|---|---|---|---|---|---|

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

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

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

7. What is your diagnosis? — ICD-9 Code

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

| 9. Did injury require hospitalization? If no, go to item # 13 ☐ Yes ☐ No | 10. Date of admission mo. day yr. | 11. Date of discharge mo. day yr. | 12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No |
|---|---|---|---|

13. What treatment did you receive?

| 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 _____ Date _____

| 29. Name of Physician | 30. Tax ID Number |
|---|---|
| Address | 31. Do you specialize? ☐ Yes ☐ No |
| City State ZIP | 32. If yes, indicate specialty |

**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