15.5 – Exhibit 01

NOTICE OF TRAUMATIC INJURY AND
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

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

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

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

**Employee Data**

| 1. Name of employee (Last, First, Middle) | | | 2. Social Security Number |
|---|---|---|---|
| Miller | Amy | K | 123-45-6789 |

| 3. Date of birth Mo. Day Yr. | 4. Sex | 5. Home telephone | 6. Grade as of date of injury |
|---|---|---|---|
| 04/25/1966 | ☐ Male ☑ Female | (208)555-1234 | Level 7 Step 2 |

7. Employee's home mailing address (Include city, state, and ZIP code)
123 Alpine Road
Burley ID 88347

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)
Warm Lake Incident Base - Tool Sharpening Area

| 10. Date injury occurred Mo. Day Yr. | Time | 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation |
|---|---|---|---|
| 07/12/2008 | 10:15 ☑ a.m. ☐ p.m. | 07/12/2008 | Forestry Technician |

13. Cause of injury (Describe what happened and why)
While sharpening a shovel, my hand slipped and my right thumb ran across the shovel's edge.

a. Occupation code

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

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** Amy K. Miller **Date** 7/12/2008

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)
I was working beside Amy Miller and I saw her cut her right thumb on a shovel edge.

| Name of witness | Signature of witness | | Date signed |
|---|---|---|---|
| Piper Lynn | Piper Lynn | | 07/12/2008 |
| **Address** | **City** | **State** | **ZIP Code** |
| P.O. Box 33333 | Boise | ID | 83704 |

Form CA-1
Rev. Apr. 1999

## 15.5 – Exhibit 01 – Continued

## NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

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

**Supervisor's Report**

17. Agency name and address of reporting office (include city, state, and zip code)
BLM - Boise District Office
OWCP Agency Code

3924 Development Avenue
OSHA Site Code

Boise ID ZIP Code 83705

18. Employee's duty station (Street address and ZIP code)
BLM - Boise District Office 3924 Development Avenue Boise ID 83705

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

20. Regular work hours From: 09:00 ☑ a.m. ☐ p.m. To: 06:00 ☐ a.m. ☑ p.m.

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

22. Date of Injury Mo. Day Yr. 07/12/2008

23. Date notice received Mo. Day Yr. 07/12/2008

24. Date stopped work Mo. Day Yr. 07/12/2008 Time: 10:15 ☑ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr. 07/13/2008

27. Date returned to work Mo. Day Yr. 07/14/2008 Time: 04:00 ☐ 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)
Dr. Converse
1313 Water Street
Boise ID 83705

33. First date medical care received Mo. Day Yr. 07/12/2008

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.
N/A

37. Pay rate when employee stopped work
$ 17.70 Per hour

**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)
Laine Schwarberg

Signature of supervisor Laine Schwarberg Date 07/12/2008

Supervisor's Title
Supply Unit Leader

Office phone
(208) 555-1212

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

Form CA-1
Rev. Apr. 1999

15.5 – Exhibit 01 – Continued

NOTICE OF TRAUMATIC INJURY AND
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

## 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.

Form CA-1
Rev. Apr. 1999

15.5 – Exhibit 01 – Continued

# NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

**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) Miller, Amy K.

Which occurred on (Mo., Day, Yr.) 07/12/2008

At (Location)

Warm Lake Incident

| Signature of Official Superior | Title | Date (Mo., Day, Yr.) |
|---|---|---|
| Wayne Brunenberg | Supply Unit Leader | 07/12/2008 |

*U.S. GPO: 1999-454-845/12704

Form CA-1
Rev. Apr. 1999

## 15.5 – Exhibit 02

## NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION, CA-2

Notice of Occupational Disease and Claim for Compensation

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

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

**Employee Data**

1. Name of Employee (Last, First, Middle): Ruby Tim S
2. Social Security Number: 123-45-6789
3. Date of birth (Mo. Day Yr.): 07/12/1959
4. Sex: M
5. Home telephone: (208)555-8181
6. Grade as of date of last exposure: Level 6 Step 5
7. Employee's home mailing address (Include city, state, and ZIP code): 285 Smoke Street, Boise ID 87045
8. Dependents: ☑ Wife, Husband ☐ Children under 18 years ☐ Other

**Claim Information**

9. Employee's occupation: Forestry Technician
a. Occupation code:
10. Location (address) where you worked when disease or illness occurred (include City, state, and ZIP code): Paper Fire on the Boise National Forest, 1275 Oakwood Road ID 87045
11. Date you first became aware of disease or illness (Mo. Day Yr.): 08/22/2008
12. Date you first realized the disease or illness was caused or aggravated by your employment (Mo. Day Yr.): 08/22/2008
13. Explain the relationship to your employment, and why you came to this realization

While working as a firefighter on the Paper Fire, I was subjected to a great amount of smoke inhalation. The smoke was caused by a slop-over in the area where I was working.

14. Nature of disease or illness: Smoke Inhalation
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.
N/A

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

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

**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** Tim S. Ruby Date 8/22/2008

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

Form CA-2
Rev. Jan. 1997

## 15.5 – Exhibit 02 – Continued

## NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION, CA-2

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

**Supervisor's Report**

19. Agency name and address of reporting office (include city, state, and ZIP Code)
USFS, ASC-HCM Workers' Compensation Section
3900 Masthead St., MS-118
Albuquerque NM 87109
OWCP Agency Code
OSHA Site Code
ZIP Code

20. Employee's duty station (Street address and ZIP Code)
NIFC 3833 S. Development Avenue Boise ID 83705
ZIP Code

21. Regular work hours From: 09:00 ☑ a.m. ☐ p.m. To: 06:00 ☐ 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)
Cascade Medical Center
4720 Deer Lane
Cascade ID 88603

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. 08/22/2008

27. Date and hour employee stopped work Mo. Day Yr. 08/22/2008 Time 02:00 ☐ 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. 08/22/2008

30. Date returned to work Mo. Day Yr. 08/23/2008 Time 08:00 ☑ a.m. ☐ p.m.

31. If employee has returned to work and work assignment has changed, describe new duties
Employee assigned light duty at the incident base and is not to be exposed to smoke for two days. Employee can return to fireline after two days.

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)
Tammy Bull

Signature of Supervisor Tammy Bull

Date 08/22/2008

Supervisor's Title
Strike Team Leader

Office phone
(208)555-1234

Form CA-2
Rev.Jan.1997

15.5 – Exhibit 02 – Continued

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION, CA-2

**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)

Ruby, Tim S.

I was first notified about this condition on (Mo., Day, Yr.) 08/22/2008

At (Location)
Paper Fire - Boise National Forest

| Signature of Official Superior | Title | Date (Mo., Day, Yr.) |
|---|---|---|
| Tammy Bell | Strike Team Leader | 08/22/2008 |

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

Form CA-2

## 15.5 – Exhibit 02 – Continued

## NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION, CA-2

**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

Form CA-2
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