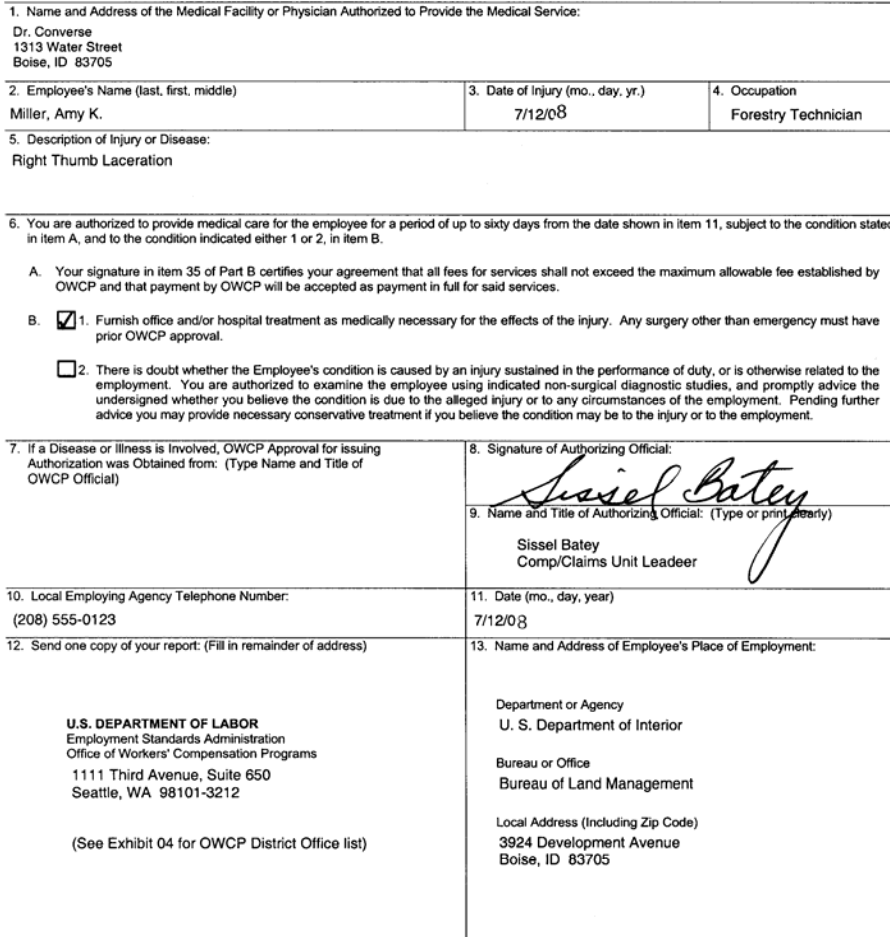
15.5 – Exhibit 03

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT, CA-16



Authorization for Examination And/Or Treatment

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

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

OMB No.: 1215-0103
Expires: 09-30-91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:
Dr. Converse
1313 Water Street
Boise, ID 83705

2. Employee's Name (last, first, middle)	3. Date of Injury (mo., day, yr.)	4. Occupation
Miller, Amy K.	7/12/08	Forestry Technician

5. Description of Injury or Disease:
Right Thumb Laceration

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

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

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

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

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

8. Signature of Authorizing Official: Sissel Batey

9. Name and Title of Authorizing Official: (Type or print clearly)
Sissel Batey
Comp/Claims Unit Leadeer

10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
(208) 555-0123	7/12/08

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

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Avenue, Suite 650
Seattle, WA 98101-3212

(See Exhibit 04 for OWCP District Office list)

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

Department or Agency
U. S. Department of Interior

Bureau or Office
Bureau of Land Management

Local Address (Including Zip Code)
3924 Development Avenue
Boise, ID 83705

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

This form was electronically produced by National Production Services Staff

Form CA-16
Rev. Oct. 1988

15.5 – Exhibit 03 – Continued

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT, CA-16

PART B - ATTENDING PHYSICIAN'S REPORT

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

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

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. ICD-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is your diagnosis?

18a. ICD-9 Code

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt.)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If Yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

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

37. Tax Identification Number

38. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
*U.S. Government Printing Office: 1990-261-871/11410

15.5 – Exhibit 04

U.S. DEPARTMENT OF LABOR OWCP DISTRICT OFFICES

U.S. Department of Labor OWCP District Offices

Based on the home mailing address of the employee listed in block 7 on the CA-1 or CA-2, use the following OWCP District Office address to properly complete block 12 on Form CA-16.

District Office 1--Boston – (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont). **U. S. Dept. of Labor, OWCP** **JFK Federal Building Room E-260,** **Boston, MA 02203**	**District Office 11--Kansas City** - (Iowa, Kansas, Missouri, and Nebraska) **U. S. Dept. of Labor, OWCP** **Two Pershing Square Building** **2300 Main Street, Suite 1090** **Kansas City, MO 64108-2416**
District Office 2--New York - (New Jersey, New York, Puerto Rico, and the Virgin Islands) U. S. Dept. of Labor, OWCP **201 Varick Street, Room 740** **New York, NY 10014**	**District Office 12--Denver** - (Colorado, Montana, No. Dakota, So. Dakota, Utah, and Wyoming) **U. S. Dept. of Labor, OWCP** **1999 Broadway, Suite 600** **Denver, CO 80202**
District Office 3--Philadelphia - (Delaware, Pennsylvania, and West Virginia; Maryland when the claimant's residence has a zip code beginning 21***) **U. S. Dept. of Labor, OWCP** **Curtis Center, Suite 715 East** **170 S. Independence Mall West** **Philadelphia, PA 19106-3308**	**District Office 13--San Francisco** - (Arizona, California, Hawaii, and Nevada) **U. S. Dept. of Labor, OWCP** **90 Seventh St., Suite 15300** **San Francisco, CA 94103**
District Office 6--Jacksonville - (Alabama, Florida, Georgia, Kentucky, Mississippi, No. Carolina, So. Carolina, and Tennessee) **U. S. Dept. of Labor, OWCP** **400 West Bay Street, Room 826** **Jacksonville, FL 32202**	**District Office 14--Seattle** - (Alaska, Idaho, Oregon, and Washington) **U. S. Dept. of Labor, OWCP** **1111 Third Avenue, Suite 650** **Seattle, WA 98101-3212**
District Office 9--Cleveland - (Indiana, Michigan, Ohio; All special claims and all areas outside the U.S., its possessions, territories and trust territories) **U. S. Dept. of Labor, OWCP** **1240 East Ninth Street, Room 851** **Cleveland, OH 44199**	**District Office 16--Dallas** - (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas) **U. S. Dept. of Labor, OWCP** **525 South Griffin Street, Room 100** **Dallas, TX 75202**
District Office 10--Chicago - (Illinois, Minnesota, Wisconsin) **U. S. Dept. of Labor, OWCP** **230 South Dearborn Street, Eighth Floor** **Chicago, IL 60604**	**District Office 25--Washington, D. C.** - (District of Columbia, Virginia; Maryland when the claimant's residence has a zip code beginning other than 21***) **U. S. Dept. of Labor, OWCP** **800 N. Capitol Street, N.W., Room 800** **Washington, D.C. 20211**

15.5 – Exhibit 04 – Continued

U.S. DEPARTMENT OF LABOR OWCP DISTRICT OFFICES

U.S. Department of Labor OWCP District Office Map

15.5 – Exhibit 05

APMC AUTHORIZATION AND MEDICAL REPORT, FS-6100-16

USDA-Forest Service FS 6100-16 (01/05)

AGENCY PROVIDED MEDICAL CARE AUTHORIZATION AND MEDICAL REPORT
(Physician or Medical Facility Form may be used for Medical Report)
(Refer to FSH 5109.34, IIBMH Chptr 10, Section 15)

Part A Authorization

1. Medical Resource Request "M Number"
M-2

2. Procurement Identification (BPA/Field PO No., etc)

3. Responsible Payment Unit
Boise National Forest

4. Employee Name
Tim Ruby 4a. Occupation **Forestry Tech**

5. Social Security No.
123-45-6789

6. Employing Agency
Forest Service, Boise National Forest

8. Date of Injury
08/22/XXXX

7. Home Unit and Address
Boise National Forest
1275 Oakwood Road
Boise, ID 87045

Send Bills To:

9. Physician/Medical Facility:
Cascade Medical Center
4720 Deer Lane
Cascade, ID 88603

9a Description of Injury or Disease:
Smoke Inhalation

Please provide initial diagnosis and treatment medically necessary for injury/illness. Surgery, other than emergency, and/or hospitalization requires further authorization. Please complete the following medical report at the time of treatment and give to the employee for return to our office.

10. Authorizing Signature (Agency Admin/Line Officer, FSC, or COMP)
Margo Hornbeck COMP

11. Date
08/22/XXXX

Part B Attending Physician's Report

1. Evaluation or Diagnosis:
Smoke inhalation resulting in a bronchial infection.

2. Description of Treatment:
Broncial therapy and medication

3. Medicine Prescribed and Potential Side Effects:
10 days antibiotics

4. Work Restrictions (if any) and length of restrictions.
Do not expose to smoke for 2 days – then can return to fireline duty. Can work in a non-smoky environment.

5. Physician's Signature
J. Worcester M.D.

6. Date
08/22/XXXX

Attachment: **Employee's** CA-1/CA-2 (white copy)
Medical Facility CA-1/CA-2 (pink copy)
Incident Unit Headquarters CA-1/CA-2 (yellow copy)

OVER

15.5 – Exhibit 05 – Continued

APMC AUTHORIZATION AND MEDICAL REPORT, FS-6100-16

Employing Office Instructions

Medical treatment for this injury/illness was provided by our Agency through procurement with medical providers under the *Agency Provided Medical Care (APMC)* program. These procedures are entirely apart from and not under the authority or provisions of FECA/OWCP, and do not require issuing a CA-16. However, a CA-1 or CA-2 was completed in all cases for the employee's protection.

Do not pay invoices or statements attached to CA forms. Do not forward to OWCP for payment if:

(1) no further medical treatment is necessary, (2) there is no lost time due to the injury/illness, and (3) this initial treatment did not involve surgery or hospitalization. Under these circumstances only, file the CA-1/CA-2 and medical documentation in the Employee's Medical Folder for record purposes.

If any one of the following conditions occurs, initiate appropriate OWCP procedures:

1. For lost time cases which occurred on the incident assignment or following the employee's return (and are supported by the attached medical documentation), but no further medical treatment is required, submit CA-1/CA-2 and the medical report from the medical provider to OWCP as part of the claim package. Provide explanation to OWCP that all medical services were paid by the Agency. Grant COP and provide form CA-3 to OWCP as appropriate in traumatic injury cases.

2. Where emergency surgery or hospitalization was provided by the medical facility in conjunction with APMC, submit CA-1/CA-2 and the medical reports to OWCP as outlined in item 1 above.

3. Where followup treatment is necessary or there is loss of wages, follow standard OWCP procedures. *This includes issuing CA-16 as appropriate to the physician of the employee's choice.* File the claim with your OWCP District Office.

Situations may arise where the physician provided by this Agency determined that the employee was fit for light or regular duty and subsequent evaluation shortly thereafter by the physician selected by the employee indicates the employee is disabled. While this requires resolution by OWCP, the employee must receive continuation of pay, if other requirements for COP are met, pending OWCP's decision.

If you have any questions or problems, please contact Incident Unit Headquarter's Compensation Specialist:

Compensation Specialist Name	**Margo Hornback**
Agency Unit Headquarters	**Boise National Forest**
Phone Number	**208-555-1212**

15.5 – Exhibit 06

SAMPLE INCIDENT INJURY/ILLNESS LOG

Incident Injury/Illness Log

INCIDENT NAME ______________________ **INCIDENT NUMBER** ______________________

EMPLOYEE NAME, HOME UNIT & PHONE #	DATE OF INJURY	M # (APMC only)	CREW NAME or OH SECTION	SUPERVISOR NAME, HOME UNIT & PHONE #	NATURE OF INJURY/ILLNESS	FORMS PREPARED	DATE FORMS TRANSMITTED TO HOME UNIT
Sample Entry - Amy Miller Boise Field Office 208-387-1122	7/12/XXXX	N/A	Supply Unit	Laine Schwarberg BLM Vale District Office 541-123-4444	Right Thumb Laceration	CA-1, CA-16	7/13/XXXX

15.5 – Exhibit 07

EMERGENCY FIREFIGHTER TIME REPORT, OF-288 SHOWING COP FOR REGULAR GOVERNMENT EMPLOYEE

EMERGENCY FIREFIGHTER TIME REPORT

1. Identification Number: F 7114472

2. Social Security Number: 123-45-6789
3. Initial Employment (X one): ☐ Yes ☐ No
4. Type of Employment (X One): ☐ Casual ☑ Regular Gov't Employee ☐ Other
5. Transferred from:
6. Hired At:
7. Employee Has (X One): ☐ Been Discharged ☐ Quit
8. Entitled to Return Travel Time (X One): ☐ Yes ☐ No
9. Entitled To Return Transportation (X One): ☐ Yes ☐ No

ZIP CODE MUST BE ENTERED BELOW	IN CASE OF EMERGENCY NOTIFY
10. Name (First, Middle, Last): Amy K. Miller	15. Name: Sam Miller
11. Street Address: BLM Boise District Office, 3924 Development Ave.	16. Street Address: 123 Alpine Road
12. City: Boise; 13. State: ID; 14. Zip Code: 83705	17. City: Burley; 18. State: ID; 19. Telephone No. (include Area Code): 208-555-1234

20. FIRE LOCATION IDENTIFICATION

	Column A	Column B	Column C	Column D
1. Fire Name	Warm Lake	Warm Lake	Warm Lake	
2. Fire No.	ID-BOD-005161	ID-BOD-005161	ID-BOD-005161	
3. Unit Code				
4. Fire Location	BOD	BOD	BOD	
5. State	ID	OR	OR	
6. Firefighter Classification	FFT2	COP	FFT2	
7. Rate	GS	GS	GS	
8. Date and Time, a. Year	XXXX	XXXX	XXXX	

A: Mo. b.	A: Day c.	A: Start d.	A: Stop e.	A: Hours f.	B: Mo. b.	B: Day c.	B: Start d.	B: Stop e.	B: Hours f.	C: Mo. b.	C: Day c.	C: Start d.	C: Stop e.	C: Hours f.	D: Mo. b.	D: Day c.	D: Start d.	D: Stop e.	D: Hours f.
07	10	1800	2200	4.00	07	13	COP		8.00	07	17	0700	1300	6.00					
07	11	0700	2100	14.00 H	07	14	0900	1300	4.00	07	17	1400	2000	6.00					
07	12	0700	1015	3.25	07	14	1400	1600	2.00	07	18	0900		T					
07	12	Guarantee		4.75							Carol Smith								
07	14	1600	1800	2.00															
07	15	0700	2100	14.00H															
07	16	0600	2000	14.00															

	Column A	Column B	Column C	Column D
9. Total Hours	56.00	14.00	12.00	
10. Gross Amount (item 7 X item 9)				
11. Inclusive Dates	07/10 - 07/16	07/13 - 07/14	07/17 -	
12. Time Officer's Signature	/s/ Carol Smith	/s/ Carol Smith	/s/ Carol Smith	
13. Date Signed	07/16/XX	07/16/XX		

21. SHOW "H" FOR HAZARD PAY AND "E" PLUS % FOR ENVIRONMENTAL DIFFERENTIAL IN THE "HOURS" COLUMN FOR REGULAR EMPLOYEES.

A. Comm. BO 2600	B. Rate	C. Miles * / Hours	D. Accounting Classification (a)	(b)	(c)	E. Object Class (a)	(b)	(c)	F. Amount

Gross Salary or Equip. Rental:
Gross Earning:
Comm. Deduct.:
Net Earning:

22. Commissary Record

a. Date	b. Item	C. Amount
07/16/XX	Toiletries	11.00
Total		11.00

24. ADO Check Number and Stamp

23. Remarks
7/12 Injured at 1015 7/14
Returned to duty at incident.

NOTE: The above items are correct and proper for payment from available appropriations.

25. Employee Signature: /s/ Amy K. Miller
26. Time Officer (Signature): /s/ Carol Smith

* Equipment rentals must be supported with OF-294 and OF-297 NSN 754-01-124-7633 OPTIONAL FORM 288 (Rev. 3/83) USDA/USDI 50288-102

ORIGINAL - PAYROLL COPY

15.5 – Exhibit 08

EMERGENCY FIREFIGHTER TIME REPORT, OF-288 SHOWING COP FOR A CASUAL

EMERGENCY FIREFIGHTER TIME REPORT

1. Identification Number: **F 7114481**
2. Social Security Number: **987- 65- 4321**
3. Initial Employment (X one): ☑ Yes ☐ No
4. Type of Employment (X One): ☑ Casual ☐ Regular Gov't Employee ☐ Other
5. Transferred from:
6. Hired At: **ID-BOD**
7. Employee Has (X One): ☐ Been Discharged ☐ Quit
8. Entitled to Return Travel Time (X One): ☑ Yes ☐ No
9. Entitled To Return Transportation (X One): ☑ Yes ☐ No

ZIP CODE MUST BE ENTERED BELOW

10. Name (First, Middle, Last): **Jose Valdez**
11. Street Address: **842 West End**
12. City: **Nampa** 13. State: **ID** 14. Zip Code: **83651**

IN CASE OF EMERGENCY NOTIFY

15. Name: **Maria Valdez**
16. Street Address: **(Same)**
17. City: 18. State: 19. Telephone No. (include Area Code): **208-555-4321**

20. FIRE LOCATION IDENTIFICATION

	Column A	Column B	Column C	Column D
1. Fire Name	Warm Lake	Warm Lake	Warm Lake	Warm Lake
2. Fire No.	ID-BOD-005161	ID-BOD-005161	ID-BOD-005161	ID-BOD-005161
3. Unit Code				
4. Fire Location	BOD	BOD	BOD	BOD
5. State	ID	OR	OR	
6. Firefighter Classification	FFT2 / AD-C	FFT2 / AD-C	COP	FFT2 / AD-C
7. Rate	13.24	13.24	13.24	13.24
8. Date and Time a. Year	XXXX	XXXX	XXXX	

A Mo. b.	A Day c.	A Start d.	A Stop e.	A Hours f.	B Mo. b.	B Day c.	B Start d.	B Stop e.	B Hours f.	C Mo. b.	C Day c.	C Start d.	C Stop e.	C Hours f.	D Mo. b.	D Day c.	D Start d.	D Stop e.	D Hours f.
08	01	2000	2400	4.00T	08	04	Guarantee		6.50	08	05	COP		8.00	08	08	1000		T
08	02	0001	0130	1.50T						08	06	COP		8.00		Carol Smith			
08	02	1800	2400	6.00						08	07	COP		8.00					
08	02	Guarantee		0.50															
08	03	0001	0800	8.00															
08	03	2000	2400	4.00															
08	04	0001	0130	1.50															

	Column A	Column B	Column C	Column D
9. Total Hours	25.50	6.50	24.00	
10. Gross Amount (item 7 X item 9)				
11. Inclusive Dates	08/01 - 08/04	4-Aug	08/05 - 08/07	
12. Time Officer's Signature	/s/ Carol Smith	/s/ Carol Smith	/s/ Carol Smith	
13. Date Signed	08/04/XX	08/04/XX	08/07/XX	

21. SHOW "H" FOR HAZARD PAY AND "E" PLUS % FOR ENVIRONMENTAL DIFFERENTIAL IN THE "HOURS" COLUMN FOR REGULAR EMPLOYEES.

A. Comm. BO 2600	B. Rate	C. Miles * / Hours	D. Accounting Classification (a)	(b)	(c)	E. Object Class (a)	(b)	(c)	F. Amount

Gross Salary or Equip. Rental

Gross Earning

Comm. Deduct.

Net Earning

22. Commissary Record

a. Date	b. Item	C. Amount
Total		

24. ADO Check Number and Stamp

23. Remarks
08/04 Injured at 0130
08/08 Released from hospital, transported home.

NOTE: The above items are correct and proper for payment from available appropriations.

25. Employee Signature: **/s/ Jose Valdez**
26. Time Officer (Signature): **/s/ Carol Smith**

* Equipment rentals must be supported with OF-294 and OF-297

NSN 754-01-124-7633

OPTIONAL FORM 288 (Rev. 3/83)
USDA/USDI
50288-102

ORIGINAL - PAYROLL COPY

15.5 – Exhibit 09

SAMPLE INCIDENT INJURY CASE FILE ENVELOPE, OF-313

NAME OF CLAIMANT *Miller, Amy*	DATE OF INJURY OR ILLNESS *7/12/xxxx*	APMC [ ] OWCP [x] FIRST AID ONLY [ ]
INCIDENT/COMPLEX NAME *Warm Lake*	INCIDENT NUMBER *ID-BOD-005161*	UNIT LOG NUMBER M-

CLAIMANT ASSIGNED TO: ____________________
(Crew Name or OH Section)

CLAIMANT'S HOME UNIT: *BLM Boise District Office*
(Agency)
3924 Development Ave.
(Address)
Boise, ID 83705
(City, State and Zip Code)
(208) 555-1212
(Telephone No. with Area Code)

SUPERVISOR ON INCIDENT: *Laine Schwarberg*

SUPERVISOR'S HOME UNIT: *BLM Boise District Office*
(Agency)
3924 Development Ave.
(Address)
Boise, ID 83705
(City, State and Zip Code)
(208) 555-1212
(Telephone No. with Area Code)

CHECK LIST FOR CASE FILES

(Indicate Whether Completed)	YES (Date)	NO
*CA-1 – Report of Injury	*7/12/xx*	
*CA-2 – Report of Illness		
CA -16 Request for Examination and/or Treatment	*7/12/xx*	
FS-6100-16 – Agency Provided Medical Care Authorization and Medical Report		
CA – 17 – Duty Status Report		
HCFA – 1500 – Health Insurance Claim Form	*7/12/xx*	
Follow-up Action Needed		

NOTE:** ***ORIGINAL **form must go to employee's home (or hiring) unit.**

Follow-up Needs/Comments: *Lost time injury; stitches need to be removed by personal physician.*

COMPENSATION FOR INJURY SPECIALIST/UNIT LEADER NAME *Sissel Batey*	HOME UNIT TELEPHONE NUMBER (W/AREA CODE) *(208) 555-1212*	FINANCE/ADMIN SECTION CHIEF INITIALS *sg*

7540-01-475-4309-50312-101 **INCIDENT INJURY CASE FILE ENVELOPE** Optional Form 313 (Rev. 4-2000)