U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF FEDERAL EMPLOYEES COMPENSATION

NOTICE OF

RECURRENCE OF DISABILITY

IMPORTANT: BEFORE COMPLETING THIS FORM PLEASE READ CAREFULLY THE INSTRUCTIONS ON THE BACK.

1. NAME OF INJURED EMPLOYEE (last first, middle)	2. SOCIAL SECURITY NUMBER	3. OFEC file number for orginal injury (If known)

4. HOME MAILING ADDRESS (Include zip code)	5. HOME TELEPHONE Area Code Number

6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury (number, street, city, state zip code)	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrance, If other than 6.

8. DATE AND HOUR of original injury (mo., day, year)	9. DATEAND HOUR of recurrance (mo., day, year)	10. DATE AND HOUR stopped work following recurrance (mo., day, year)	11. DATE AND HOUR pay stopped following recurrnace (mo., day, year)
☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.

12. PAY RATE IN EFFECT ON:	a. Base pay	b. Subsistance	c. Quarters	d. Other pay
A. Date of Recurance	$ per	$ per	$ per	$ per
B. Date Stopped Work Following Recurrance	$ per	$ per	$ per	$ per

13. Show work week at time pay stopped, If other than Monday thru Friday	14. DATE AND HOUR returned to work, following recurrance (mo., day, year)	15. At time of reccurance did official superior authorized medical treatment?
S M T W T F S	☐ a.m. ☐ p.m.	☐ YES ☐ NO

16. DATE employee first received medical reatment following recurrance (mo., day, year)	17. NAME AND ADDRESS of phyisican treating employee following recurrance

I8. Dscrlbe the clrcumstances of the recurrance of dlsability as reported by the employee. If hls condition gradually worsened over a period of time, descride the progress of the condition from the time he returned to work up to date of recurrance.

19. Ater returnlng to work followlng the original Inury, was the employee handicapped on in any way limited in performing his usual duties

☐ YES ☐ NO (If yes, explain)

20. Signature of official superior (at time of recurrance)	21. Title	22. Official superior's work phone number	23. DATE (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a
RECURRENCE OF DISABILITY

Definition of Recurrence: When, after retuning to work, an injured employee is again disabled and stops work as a result of the original injury or occupational disease, such disability is considered by OFEC to be a recurrence. In these instances a form CA-2a is required. If a new incident occurs, the matter should be treated as a new injury and form CA-I & 2, etc., submitted accordingly.

1. Form CA-2a should be submitted promptly by the official superior upon receiving notice that the employee has suffered a recurrence.

2. If the original injury was not previously reported to OFEC, a report specifically covering the original injury should be made on form CA-I & 2 and attached when form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted-.

3. When the employee has received medical care as a result of the recurrence, a detalled medical report should be submitted by the attending physician. The report should Include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between employees condition and the original injury.

   If the employee was treated by other physicians after returning to work following his original injury, similar medical reports should be obtained from each.

4. If the recurrence happened six months or more after the employee returned to duty following the original injury, A STATEMENT FROM THE EMPLOYEE SHOULD ACCOMPANY THE FORM CA-2a. The statement should describe the employee's duties upon his return to work, state whether he had any other injuries or illness and give a general description of his physical condition during the intervening period.

5. If the employee wishes to claim compensation as a result of the recurrence and a form CA-4 was not submitted following the original injury one should be submitted at this time. If form CA-4 was previously filed, compensation may be claimed by filing form CA-8. A medical report on form CA-20 (or in narrative form) must also be completed in accordance with the applicable instructions.

6. If the recurrent disability has not ended at the time form CA-2a is submitted, form CA-3, Termination of Disability, should be forwarded when the employee returns to work.

7. In the event the employee is not able to return to his same duties and suffers pay loss as a result of his disability, he may be entitled to additional compensation based on loss of wages, or loss of wage earning capacity. Upon notification of such loss, OFEC will advise the employee of the procedure to follow to claim additional compensation.

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