Federal Employee's Notice of Traumatlc 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 113.
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 . ☐ am . ☐ pm

11. Date of this notice Mo. Day Yr.

12. Employee's occupation

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

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

a. Occupation code

b. Type code

c. Source code

QWCP 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 persecution 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 or 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. Sept. 1993

Official Supervisor's Report: Please complete Information requested below: **MS 682-B Page 2**

Supervisor' 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) ZIP Code

19. Regular work hours From ☐ a.m. ☐ p.m. To ☐ a.m. ☐ p.m.

20. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues ☐ Wed. ☐ Thur. ☐ Fri. ☐ Sat.

21. Date 0f Injury Mo. Day Yr.

22. Date notice received Mo. Day Yr.

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

24- Date pay stopped Mo. Day Yr.

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

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

27. Was employee injured in performanceof duty? ☐ Yes ☐ No (If No, explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another O Yes (If Yes, explain) a No

29. Was injury caused by third party? ☐ yes ☐ No (If"No, go to Item 31.)"

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

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

32. First date medical care recieved Mo. Day Yr.

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

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

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

36. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filling instructions

37. 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 persecution.

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

Suirvisor's Title | Office phone

38. Filing instructions

- ❑ No lost time and no medical expense: Place this form in employee's medical folder (SFD)
- ❑ 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

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 d id you 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 file CA-1 within thirty days of the injury, you are 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- You may elect sick or annual leave during the 45 days of COP entitlement (You may not claim compensation to repurchase leave used during this period.) Also, if you change your election within one year, the agency is obliged to convert past periods of leave to COP, which qualify.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received complete the receipt of notice 0f injury and give it to the employee. In addition to completing items 17 through 38, 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.

29) 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

32) First date medical care received
The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?

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 results from an occupational disease or illness;

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 neither 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, intoxication;

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

9) Work stoppage first occurred 90 days or more following he injury;

injury, could all be considered third parties to the injury.

31) Name and address o physician third 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.

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- Cod-), Box c (Source- Code) OSH 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 201., Record keeping 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 ot compensation office, or by contacting OWCP.

Disability Benefits to Employees under the Federal Employees' Comp-nation 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; however, to avoid possible interruption °f pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)

(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such 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 disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee s choice- Generally, 2s miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

(1) The employing agency receives medical information from the attending physician to the effect that disability has terminated-

(2) The OWCP advises that pay should be terminated; or

(3) The expiration of 45 calendar days following initial work stopped-

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, 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. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

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 Managements Federal Personnel Manual

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 of1988 (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. (s) 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 voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. 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 benefit and payment files.)

|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 Supervisor	Title	Date (Mo., day, Yr.)