U.S DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF FEDERAL EMPLOYEES' COMPENSATION (OFEC)	**CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY**

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*	2. OFEC FILE NUMBER, IF KNOWN
Doe, John	
3. HOME MAILING ADDRESS *(Include zip code)*	4. SOCIAL SECURITY NUMBER
c/o American Embassy Quito, Ecuador	000-11-2222
5. DATE AND HOUR OF INJURY *(Mo., day, year)* January 1, 1982 [] AM [] PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* FROM: 1/1/82 THROUGH: 1/15/82
7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6.? [] YES [] NO IF YES, COMPLETE ITEM 8	8. AMOUNT RECEIVED $ 520 DATES COVERED BY LEAVE PAY FROM: 1/1/82 THROUGH: 1/15/82

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER
N/A	N/A	N/A	N/A	N/A

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING: N/A

REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING

Used "sick leave" from January 1, 1982 - January 15, 1982

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION (FORM CA-4), YOU HAVE APPLIED FOR OR RECEIVED COMPENSATION, PENSION, RETIREMENT, OR RETAINER PAY BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO.	NATURE OF DISABILITY AND MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
N/A		

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION (FORM CA-4), YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO.	NATURE OF DISABILITY AND MONTHLY PAYMENT	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
N/A		

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON HIS BEHALF	15. DATE *(Mo., day, year)*
	January 16, 1982

Form CA-8 Revised Nov. 1972

STATEMENT OF OFFICIAL SUPERIOR

JAN 31, 1983

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR
January 16, 1982 [] AM [] PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY
S | M | T | W | T | F | S

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6.ON THE REVERSE SIDE?
[] YES [] NO

19. IF ANSWER TO ITEM 18. IS YES, SHOW:
AMOUNT: $ 1,498 (10 Days)
TYPE OF PAYMENT: Sick Pay
PERIOD: FROM: 1/1/82 THROUGH: 1/15/82

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE FORM CA-4 WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

None

21. REMARKS

None

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(Mo., day, year)*
	PC Staff Director	1/16/82

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1. through 15. on the reverse side should be completed by the injured employee or someone acting on his behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OFEC. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OFEC or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16. through 24. and forward the form to the appropriate OFEC office.

b. The official superior must also complete items 1. through 6. on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3. on the reverse of the Form CA-20a, the address of the OFEC office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL, EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.