U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

REPORT OF TERMINATION OF DISABILITY AND/OR PAYMENT

PART A GENERAL

1. Name of Injured Employee (Last, first, middle)	2. Social Security Number	3. OWCP File Number (If known)
DOE, JOHN HENRY	000-00-0000	A50-1212

4. Department or Agency	5. Bureau or Office
PEACE CORPS	OFFICE OF MEDICAL SERVICES

6. Name and Address of Reporting Office (1 Include Zip Code)

Peace Corps , 806 Connecticut Ave., N.W.
Washington, D.C. 20526

7. Date and Hour of' Injury (Mo., day, year)	8. Date and Hour Stopped Work (Mo., day, year)	9. Date and Hour Pay Stopped (Mo., day, year)	10. Date and Hour Returned to Work (Mo., day, year)
9/ 21/ 82 ☐ AM ☐ PM	9/ 21/ 82 ☐ AM ☐ PM	11/04 /82 ☐ AM ☐ PM	11/04 /82 ☐ AM ☐ PM

11. Employee's Work Work On Return To Duty If Other Than Monday Through Friday

S (M T W T F)

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work.

a. Base Pay	b. Sussistance	c. Quarters	d. Other (Specify

13. Exclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Lease	c. Other speak;fy)
From: None Through:	From: None Through:	Continuation of Pay (COP) From: 9/2/82 Through: 11/04/82

14. Has Employee's Work Assignment Been Changed because of Disability Resulting From This Injury?

☐ Yes ☐ No If Yes, Describe The Type of Work Employee Is Performing.

15. I interrupted, Show Dates Deductions For Health Benefits all/or Optional Insurance Were Resumed Mo., day, year)	16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year)
Health Benefits Optional Insurance	Number ____________________ Date ________________

17. Remarks:

PART B CONTINUATION OF PAY

18. Exclusive Dates That Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day yr.)	9. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick or annual leave.
From: 9/22/2l Through: 11/04/82	$2,015.00

20. It Pay Rate Change During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)	21. If Rate Changed During The Period Employee Was Receiving Continuation of Pay Give New Rate			
	a. Base Pay	b. Sussistance	c. Quarters	d. Other (Specify
Same				

22. Signature of Supervisor	23. Title and Office Phone Number Chief of Operations	24. Date (Mo., day, year)
Frances Medina	254-0000	11/24/82

Form CA-3
Rev. Dec. 1974
ATTACHMENT J
MS 682
Page 2
JAN 31 1983

INSTRUCTIONS FOR COMPLETING FORM CA-3 WHEN EMPLOYEE RETURNS TO WORK

PART - A

REQUIRED WRITTEN REPORT

- When disability ceases and/or employee returns to work, the official superior shall immediately report that fact to the OWCP on Form CA-3 unless this information has been previously submitted on Form CA-I or CA-2 or otherwise. This form should be submitted for each injury resulting in time lost from work whether or not claim for compensation is made.

TELEPHONE/ TELEGRAPH REPORT

- If the employee is receiving disability compensation periodically each four weeks, the official superior should immediately telephone or telegraph the OWCP advising the date employee returned to work. This will avoid n overpayment of compensation. Follow-up should then be made with Form CA-3.

PAY RATE FORMATION

- Employee's base pay in items 12a or 21a should not include value of subsistence, quarters or other pay. These should be shown seprately in their own columns.

PART - B

CONTINUATION OF PAY

- In most traumatic injury cases, the employee will have qualified for and receive continuation of pay under 5 USC 8118 (FECA). When this occurs items 9, 13, and 15 in Part A will usually be left: blank. When there is a continuation of pay, Part B must always be completed unless the information has been submitted on Form CA-7, Claim for Compensation on Amount of Traumatic Injury.

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