RECURRENCE

A recurrence is defined as a spontaneous return or increase of disability due to a previous injury or occupational disease without intervening cause, or a return or increase of disability due to a consequential injury. A recurrence differs from a new injury in that with a recurrence, no event other than the previous injury accounts for the disability. Follow-up medical care for an injury or disease which causes time loss is considered part of the original injury rather than a recurrence unless the employee was previously released from treatment.

If a recurrence develops, the employee and supervisor should complete Form CA-2a and submit it to the DHRC-I. If the employee was entitled to use COP and the 45 calendar days of COP have not been exhausted, he or she may elect to use the remaining days if 90 days have not elapsed since first return to duty. Otherwise, the employee may elect to use sick or annual leave pending adjudication of the claim for recurrence. The employee should arrange for submission of the factual and medical evidence described in the instructions attached to the form, paying particular attention to the need for "bridging" information which describes his or her condition and job duties between the original injury and the recurrence.

Notice of Recurrence

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

Employee: Complete Part A below. Employing Agency (Supervisor or Complete Persons are not required to respond to respond to number.	Compensati				lid OMB	OMB No. 1215-0167 Expires: 05-31-02
Part A - Employee						
Name of employee (Last, First, Midd	ile)		2. Soci	al Security Number	3. OWO injur	CP file number for original y
4. Date of birth Mo. Day Yr.	5. Sex	e	6. Home tel	•		
7. Home mailing address (include city	, state, and Z	IP code)		-	3. Dependents Wife, Hu Children Other	
Name and Address of Employing Agat time of original injury (number, st	jency reet, city, sta	ate, ZIP code)	if ot	ne and Address of Emp her than shown in 9. If eral Government, comp	vou are no lon	ger employed with the
11. Date and Hour of original injury (mo., day, year) 12. Date an of recur (mo., day)	rence	13. Date and Hou work after red (mo., day, ye	currence	14. Date and Hour pa after recurrence (mo., day, year)	ay stopped 15	5. Date and Hour returned to work (mo., day, year)
Medical Treatment Only Time Loss From Work		Date of first medica following recurrent (mo., day, year)		18. Name and addres	ss of treating pl	hysician
(If so, explain. Also state how lon 20. Describe your condition since you			nature and fre	equency of all medical	treatment rece	ived.
21. Describe how and when the recurr	ence happen	ned. Explain why y	ou believe yo	our current condition is	related to the	original injury.
22. Describe all injuries and illnesses of Arrange for the submission of all r			date you retu	urned to work after the	original injury,	and the date of recurrence
Any person who knowingly makes compensation as provided by the that person is not entitled, is subjappropriate criminal provisions, but hereby claim medical treatment I hereby authorize any physician desired information to the U.S. De This authorization also permits and	Federal Em ect to civil e punished if needed, a or hospital partment of ny official r	ployees' Comper or administrativ by a fine or imp and up to 45 days (or any other per f Labor, Office of epresentative of	esation Act (e remedies a risonment or s Continuati rson, institut t Workers' C the Office t	(FECA), or who know as well as felony crir r both. on of Pay if disabled tion, corporation, or ompensation Progra o examine and to co	ringly accepts ninal prosecu I for work. government a ms (or to its o py any recore	s compensation to which tion and may, under agency) to furnish any official representative).
I certify, under penalty of law, the 23. Signature of employee	at the inforr	mation provided	on this form		Date (mo., da	
						Form CA-2a

Pa	rrt B - Federal Employing Agency			
25.	Name and address of reporting office (include city, state, and ZIP Code)	-		OWCP Agency Code
				·
	·	ZIP	Code	OSHA Site Code
			e e	
26	Employee's duty station (street address and ZIP Code)		27. Date of first ret	urn to FULL- TIME REGULAR
20.	Employed a daty station (effect address and		duty following	
	-	_	Mo. Day Y	r. ()
			LL	
28.	Regular 29. Reg	ular Sun.	Tues.	Thurs.
	work a.m. a.m. wor hours From: p.m. To:	` =	Wed.	Fri. Sat.
30.	Date Mo. Day Yr. 31. Date Mo. Day Yr. 32	. Date M	lo. Day Yr.	a.m.
	injury recurrence	work after recurrence	<u> </u> Ti	me p.m.
33.	Date 34. Dates COP Mo. Day pay stopped paid for From	Yr. 35. Date returned	!	
	after Mo. Day Yr. recurrence To	to work after recurren	Mo. Day Yr.	I Time a.m.
36	Did the employee receive medical care at an agency facility	37. At the time c	of the recurrence did	vour —
	due to the recurrence? If so, please attach all relevant medical records. Yes No	agency auth on Form CA	norize medical treatm -16?	ent Yes No
38.	After the original injury, did you make any accommodations or adjustme	ents in the employee's	s regular duties due t	o injury-related limitation?
	Yes No If so, provide full details.			
39.	After return to work, did the employee sustain any other injury or illness provide full details.	which affected perfor	rmance of his or her	duties? If so,
	provide ign details.			
40.	Please review the statements made by the employee in Part A of this for	rm and provide any re	elevant comments and	additional information.
				on conscience
A s	supervisor or compensation specialist who knowingly certifies to fact, etc., in respect to this claim may also be subject to approp	riate felony crimina	iii, misrepresentati il prosecution.	on, concealment
41.	Signature of Supervisor or Compensation Specialist 42. Title (at time of recurrence)		43. Work phone	44. Date (mo., day, year)
	(at time of recuirement)		()	
				

Form CA-2a Rev. Sept. 1994

Part C - Employee (To be completed by the employee if not employed with the Federal Government at the tin	ne of the claimed recurrence)
For all jobs held since you left the job held when the initial injury occurred, list the full inclusive dates of employment. Include any self-employment.	name and address of your employers, and the
O. For all inha listed in item 1 above, provide year inhatite, pature of duties performed an	mbox of bours worked any week and rate of any
For all jobs listed in item 1 above, provide your job title, nature of duties performed, null	mber of nours worked per week and rate of pay.
3. Describe all educational and/or vocational training received since your original injury.	Include any licenses or certificates earned.
4. What was your rate of pay if you stopped work due to this recurrence?	
\$ per	
5. Do you claim compensation for lost wages? Yes No	
If so, for what period? through	
6. Have you received any pay during the period claimed? Yes No If so, how much and from what source?	
Section 8101, et seq., Title 5 to the U.S. Code authorizes collection of this information. Co the timely filing of a notice of recurrence of disability and claim for benefits under the Fed The information will be used to initiate and assist in the adjudication of the claim and failu claim processing. Additional disclosures of this information may be to: third parties in liti and organizations providing related medical rehabilitation and other services; insurance particularly as a processing of the processing of the federal, state and local agencies (including the Gallot to the Department of Labor; debt collection agencies and credit bureaus.	leral Employees' Compensation Act (FECA). The to provide the information may prevent or delay igation; employing agencies; various individuals blans which may have paid related bills; labor unions;
7. Signature of Employee	8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work- related injury. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal
 must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form.
 Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer
 work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers'
 Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment; history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. The physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original injury. Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations.
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless: the claimant is still receiving
 continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting
 neither wage-loss compensation nor payment of medical expenses. In these instances, file the form in the Employee Medical
 Folder.
- If COP is being paid, obtain medical evidence using Form CA-17,"Duty Status Report", as often as circumstances indicate.
- For a recurrence less than 90 days after the employee's return to work following the original injury, you may authorize required medical care using Form CA-16. For a recurrence more than 90 days after the employee's return to work, OWCP must authorize further medical care.
- For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 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. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, DC 20210.

Notice of Recurrence

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



Employee: Complete Part A below. OMB No. 1215-0167 Employing Agency (Supervisor or Compensation Specialist): Complete Part B. Expires: 07-31-08 Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Part A - Employee 1. Name of employee (Last, First, Middle) 2. Social Security Number 3. OWCP file number for original injury 250000000 John D 111-11-1111 4. Date of birth Mo. Day Yr. 5. Sex 6. Home telephone 06/30/1954 X Male Female (123)456-7891 7. Home mailing address (include city, state, and ZIP code) 8. Dependents 679 Bean Street Wife, Husband Children under 18 years Anywhere VA 22222 Other Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code) Name and Address of Employing Agency at time of recurrence, if other than shown in 9. It you are no longer employed with the Federal Government, complete Part C also. Defense Logistics Agency-HQ Same 8725 John J. Kingman Road 22222 Ft. Belvoir, VA 22060 11. Date and Hour 13. Date and Hour stopped 12. Date and Hour Rate and Nour pay stopped 15. Date and Hour of original injury (mo., day, year) of recurrence (mo., day, year) work after recurrence after recurrence returned to work (mo., day, year) (mo, day, year) (mo., day, year) 01/30/2004 05/05/2004 05/06/20049 07/29/2004 06:30 am 07:30 am 07:00 am 17. Date of first/medical treatment following recurrence (mo., day, year) 18. Name and address of freating physician Medical Treatment Only Dr. Henry Bombay Time Loss From Work 123 Hope Street 05/05/2004 VA 11111 19. After returning to work following the original injury, were you in any way X No Vimited in performing your usual Yes duties? (If so, explain. Also state how long these limitations continued.) 20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received. Radiating pain in neck and shoulder are 21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury. Constantly throbbing in neck/shoulder area. Because it is in the same area that I injured and I have sustained any new injuries in that area. 22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records. None 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 Federal Employees' Compensation Act (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 prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work. 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. certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge. 23. Signature of employee 24. Date (mo., day, year)

25. Name and address of reporting office (include of	xry, state, and ∠IP (Code)			OWCP Agency Code
Injury Compensation Center, DHRC-I					**************************************
8725 John J. Kingman Road, Stop 6231			ZIP	Code	OSHA Site Code
Ft, Belvoir		VA	2206	60	
Employee's duty station (street address and ZIP	Code)		······································	27. Date of first ret	um to FULL- TIME REGULAR
Defense Logistics Agency, HQ				duty following	original injury
8725 John J. Kingman Road			ZIP Code	Mo. Day	
Ft. Belvoir		VA	22060	07/29/200	4
8. Regular X a.m.	T . = 2	9. Regular work	Sun.	Tues.	Thurs.
hours From: 07:00 p.m. To:03:	30 ⊠ p.m.	work days	Mon.	Wed.	Fri. Sat.
0. Date Mo. Day Yr. 31. Date of recurrence	Mo. Day Yr. 05/05/2004	32. Date stopp work recur	ad .	o. Day Yr. 5/06/2004	Time 07:00 a.m.
3. Date pay stopped after Mo. Day Yr.	From	Day Yr.	35. Date returned	Mo. Day Yr.	
recurrence	То		to work after recurren	07/29/2004	Time 07:00 a.m. p.m.
 Did the employee receive medical care at an due to the recurrence? If so, please attach all relevant medical record 	- ' - 1	Yes 37	At the time of agency authors on Form CA-	f the recurrence or prize medical trea 16?	fid your Yes
B. After the original injury, did you make any ac	commodations or	adjustments	in the employe	e's regular duties	
None required.					
After return to work, did the employee sustair provide full details.	any other injury o	or illness which	ch affected per	formance of his o	r her duties? If so,
. Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
. Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
. Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
. Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
. Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
. Please review the statements made by the en	nployee in Part A o	of this form a	nd provide any	relevant comme	nts and additional information
Please review the statements made by the en	nployee in Part A	of this form a	nd provide any	relevant comme	nts and additional information
supervisor or compensation specialist who kn fact, etc., in respect to this claim may also be su			atement, misn nal prosecution	epresentation, co	ncealment
Supervisor or compensation specialist who know fact, etc., in respect to this claim may also be sure Signature of Supervisor or Compensation Specialist (at time of recurrence)	owingly certifies to bject to appropriate		atement, misn nal prosecution 43.		

on de la company de la comp

To be completed by the employee if not employed with the Federal Government at the	time of the claimed recurrence)
. For all jobs held since you left the job held when the initial injury occurred, list the fi inclusive dates of employment. Include any self-employment.	ull name and address of your employers, and the
Not applicable	
. For all jobs listed in item 1 above, provide your job title, nature of duties performed,	number of hours worked per week and rate of pay.
Describe all educational and/or vocational training received since your original inju	ry, Include any licenses or certificates earned.
None	
. What was your rate of pay if you stopped work due to this recurrence?	
\$ 50,023.00 per year	
. Do you claim compensation for lost wages? X Yes No	
If so, for what period? 05/06/2004 through 07/28/2004	
. Have you received any pay during the period claimed? Yes No	
If so, how much and from what source?	
NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC is amended. The authority for requesting the following information is Section 8101, et seq. nandatory in order to ensure the timely filing of a notice of recurrence of disability and Compensation Act (FECA). The information will be used to initiate and assist in the adjunction may prevent or delay claim processing. Additional disclosures of this information may prevent or delay claim processing related medical rehabilitational related bills; labor unions; various law enforcement officials; other federal, state a appropriate; data processing contractors to the Department of Labor, debt collection ag	, Title 5 to the U.S. Code. Completion of this form is claim for benefits under the Federal Employees' judication of the claim and failure to provide the mation may be to: third parties in litigation; employing on and other services; insurance plans which may have and local agencies (including the GAO and IRS) as
. Signature of Employee	8. Date (mo., day, year)