TRAUMATIC INJURY

A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable by time and place of occurrence and member of the body affected; it must be caused by a specific event or incident or series of events or incidents within a single day or work shift. Traumatic injuries also include damage to or destruction of prosthetic devices or appliances, including eyeglasses, contact lenses, and hearing aids, if they were damaged incidental to a personal injury requiring medical services. (Personal property claims can be made only under the Military Personnel and Civilian Employees' Claims Act, 31 U.S.C. 240.)

A. *Notice of Injury--Form CA-1.* When an employee sustains a traumatic injury in the performance of duty, he or she should file a written report on Form CA-1. The form should be given to the supervisor as soon as possible, but not later than 30 days from the date of injury. If the employee is incapacitated, this action may be taken by someone acting on his or her behalf, including a family member, union official, or representative. (The supervisor may provide such notice as well.) The form must contain the original signature of the person giving notice. The supervisor should:

(1) Review the front of the form for completeness and accuracy, and assist the employee in correcting any deficiencies found;

(2) Complete and sign the reverse of Form CA-1, including a telephone number.

(3) Sign and return to the employee the receipt attached to Form CA-1 and give a copy of the entire form to the employee;

(4) Authorize medical care if needed in accordance with paragraph (C) below;

(5) Inform the employee of the right to elect continuation of regular pay (COP), or annual or sick leave if time loss will occur;

(6) Advise the employee whether COP will be controverted, and if so, whether pay will be terminated. The basis for the action must be explained to the employee.

(7) Advise the employee of his or her responsibility to submit prima facie medical evidence of disability within 10 working days or risk termination of COP.

B. *Disposition of Form CA-1.*

If the employee incurs medical expense or loses time from work beyond the date of injury, the supervisor should send Form CA-1 to DHRC-I office with supporting information as soon as possible but no later than 2 working days after receipt of Form CA-1 from the employee.

If the employee is examined or treated at the agency's medical facilities or by medical providers under contract to the agency, and this examination or treatment occurs during working hours beyond the date of injury, the supervisor should add the words "first aid" to the upper right corner of the agency's portion of Form CA-1 and submit it to DHRC-I. "First aid" injuries also include those requiring two or more visits to a medical facility for examination or treatment during non-duty hours beyond the date of injury, as long as no leave or continuation of pay is charged and no medical expense is incurred.

If the employee obtains no medical care, or obtains only agency-sponsored care on the date of injury, and no time loss is charged to either leave or continuation of pay, the supervisor should still forward the Form CA-1 to DHRC-I where it will be retained in the Agency's files.

C. *Medical Treatment--Form CA-16.* If an employee requires medical treatment for the injury, the supervisor should complete the front of Form CA-16, *Authorization for Treatment*, within four hours of the request whenever possible. If the supervisor doubts whether the employee's condition is related to the employment, he or she should so indicate on the form. Where there is no time to complete a Form CA-16, the supervisor may authorize medical treatment by telephone and send the completed form to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is usually not permitted under other circumstances.

(1) Delayed Report of Injury. If an employee reported an injury several days after the fact, or did not request medical treatment within 24 hours of the injury, the supervisor may still authorize medical care using Form CA-16. Agency personnel are encouraged to use discretion in issuing authorizations for medical care under such circumstances, but employees should not be penalized for short delays in reporting injuries. The supervisor may, however, refuse to issue a CA-16 if more than a week has passed since the injury on the basis that the need for immediate treatment would become apparent in that period of time. An employee may not use Form CA-16 to authorize his or her own treatment.

(2) Choice of Physician. The employee is entitled to select the physician who is to provide treatment. The provider must meet the definition of "physician" under the Federal Employees' Compensation Act and must not have been excluded from payment under the program. Physicians employed by or under contract to the agency may examine the employee at the agency's facility in accordance with Office of Personnel Management regulations. However, the employee's choice of physician must be honored, and treatment by the employee's physician must not be delayed for the purpose of obtaining an agency-directed medical examination.

(3) Obtaining Treatment. Along with Form CA-16, the supervisor should give the employee Form OWCP-1500 (or HCFA-1500), which is used for billing. The physician should complete the reverse of Form CA-16 and the OWCP-1500 (or HCFA-1500) and forward them to DHRC-I; the supervisor may ask the physician for a copy of the report as well. The employee may be furnished transportation and/or reimbursed for travel and incidental expenses. The U.S. Department of Labor, Office of Workers' Compensation

Programs (OWCP) generally considers 25 miles from the agency or the employee's home a reasonable distance to travel for medical care unless appropriate care is not available within that radius.

(4) Further Referral. The original treating physician may wish to refer the employee for additional testing or specialized treatment. He or she may do so on the basis of the Form CA-16 already issued; it is not necessary to issue additional authorizations for treatment. Both the original physician, and any physician to whom the employee is referred, are guaranteed payment for 60 days from the date of issue of Form CA-16 unless OWCP terminates this authority at an earlier date. Treatment may continue at OWCP expense if the claim is approved. Should the employee wish to change physicians after the initial choice, he or she must contact OWCP in writing for approval and include the reasons for requesting the change.

Federal Employee's Notice of Traumatic 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 16.
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 ☐ a.m. ☐ p.m. | 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
OWCP 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:

☐ b. 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.

☐ a. 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 prosecution 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 for 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

Official Supervisor's Report: Please complete information requested below:

Supervisor's 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)

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

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

25. Date pay stopped Mo. Day Yr.

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

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

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

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

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

33. First date medical care received Mo. Day Yr.

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

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

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

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

38. 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 prosecution.

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

Supervisor's Title | Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ 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 did you fall and in 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 filed CA-1 within thirty days of the injury, you may be 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. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, 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.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

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

32) Name and address of physician first 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.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

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

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 was not caused by a traumatic injury.

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 not 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, or intoxication;

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

g) Work stoppage first occurred 45 days or more following the injury;

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 Code), Box c (Source Code), OSHA 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 2014, "Recordkeeping 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 or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation 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 and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, 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.

(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 defringement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN), and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

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 Superior | Title | Date (Mo., Day, Yr.)

*U.S. GPO: 1999-454-845/12704

Federal Employee's Notice of Traumatic 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 16.
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
Doe, John			XXX-XX-XXXX
2. Date of Birth Mo., Day, Year	4. Sex	5. Home telephone	6. Grade as of date of injury
06/30/54	M	(703) 222-2222	GS-201-12

7. Employee's home mailing address (include city, state and zip code)	8. Dependents
679 Bean Street Anywhere, US 22222	☒ Wife, Husband ☐ Children Under 18 years ☐ Other

Description of Injury

9. Place where occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
Parking lot at HQ-DLA at Ft. Belvoir

10. Date injury occurred (Mo., Day, Yr.)	Time		11. Date of this notice	12. Employee's job title
01/29/04	06:30	☒ a.m. ☐ p.m.	01/29/04	Human Resources Specialist

13. Cause of injury (Describe what happened and why)
I was walking across the parking lot to enter the building. I slipped and fell on a patch of ice.

a. Occupation Code	
GS-2201	
b. Type code	c. Source Code
200	0110
OWCP Use - NOI Code	

14. Nature of injury (identify both the injury and the part of body, e.g. fracture of left leg)
Left shoulder, left elbow and lower back

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:

☒ 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.

☐ 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 _____

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 felony criminal prosecution and may, under appropriate 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 for your records.

End of Employee Report

Witness

16. Statement of Witness (Describe what you saw, heard, or know about this injury)

Walking toward the building a saw Mr. Doe slipped on what appeared to be a patch of ice. Help Mr. Doe to the nurse's station

Name of Witness	Signature of Witness		Date signed
Mary Jane	/s/		01/29/04
Address	City	State	Zip Code
8756 Love Lane	Hope City,	US	33333

CA-1
(Rev. 3/86)

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

17. Agency Name and address of reporting office (include city, state and zip code)
Defense Logistics Agency
8725 John J. Kingman Rd, Stop 6231
Ft. Belvoir 22060

OWCP Agency Code: 3019

OSHA Site Code:

18. Employee's duty station (Street Address and zip code)
8725 John J. Kingman Rd, Ft. Belvoir 22060 Room 1232

19. Regular work hours From: 7:00 ☒ a. m. ☐ p. m. To: 3: 00 ☐ a. m. ☒ p. m.

20. Regular Work Schedule ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

21. Date of Injury 01/29/04

22. Date notice received 01/30/04

23. Date stopped worked 01/29/04 07:00 ☒ A. M. ☐ P. M.

24. Date pay stopped N/A

22. Date 45 day period began 01/30/04

23. Date returned to work Has not returned ☐ A. M. ☐ P. M.

27. Was employee injured in performance of duty? ☒ Yes ☐ No (If "No", explain)
Employee was on his way into the building.

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

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, zip code)

31. Name and address of physician first providing medical care (include city, state, zip code)
Dr. Henry Bombay
123 Hope Street
Anytown, US 11111

32. First date medical care received 01/29/04

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

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. Does the employing agency controvert continuation of pay? ☐ Yes (If "Yes", explain ☒ No (See instructions for explanation of "controvert"

36. Pay rate when employee stopped work
$ 29.06 per hour

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of facts, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

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)
John Henry

Signature of supervisor
/signature/

Date
01/30/04

Supervisor's Title
Supervisory Human Resources Specialist

Office Telephone
703-767-1111

38. Filing Instructions
☐ No lost time and no medical expenses. Place this form in employee's medical folder (SF-66-D)
☐ 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

CA-1
(Rev. 3/86)

Authorization for Examination And/Or Treatment

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

The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0103
Expires: 10-31-2008

PART A - AUTHORIZATION

1. Name and Address of the Medical, Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)	3. Date of Injury (mo. day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 1 1, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment.Pending further advice you may provide. necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official: 9. Name and Title of Authorizing Official: (Type or print clearly)
10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
12. Send one copy of your report: (Fill in remainder of address) **U.S. DEPARTMENT OF LABOR** Employment Standards Administration Office of Workers' Compensation Programs	13. Name and Address of Employee's Place of Employment: Department of Agency Bureau or Office Local Address (including ZIP Code)

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, 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 these estimates or any other aspect of 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, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

15. What History or Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment?
(If yes, please describe)
☐ Yes ☐ No

16a. IDC-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

18a. IDC-9 Code

19. Do You believe the Condition Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee Is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical office or hospital or any duly qualified physician/ hospital of the employee's choice.

- If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

- A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

- Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MDs), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In care of illness or disease, only Box B2 may be checked.

- Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician -- See Reverse Side

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated eadier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A. Item 12.

This form covers office visits and consultations, laboratory work, hospital services (including inpatient), x-rays, MRIs, CT scans, physical therapy, emergency services (including surgery) and chiropractic services. Chiropractic services are limited to charges for physical examinations and x-rays to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

This form does not cover elective and non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym membership and work hardening programs.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 39, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified. In Column 24 C of the form, by the applicable Current Procedural Terminology (0 editor) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identified in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

* U.S. GPO: 1999-454-845/92710

PRIVACY ACT

"NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 81 01, et seq., Title 5 of the U.S. Code authorizes collection of this information. Completion of this form is required in order to receive payment for medical services and expenses associated with the injury or disease described in Item 5 of this form for a period not more than 60 days from the date of issuance, subject to the condition in Item 6 of this form. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."

Duty Status Report

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0103
Expires: 08-31-02

OWCP File Number (If known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)

2. Date of Injury (Month, day, yr.) | 3. Social Security No.

4. Occupation

5. Describe How the Injury Occurred and State Parts of the Body Affected

6. The Employee Works
Hours Per Day Days Per Week

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day
b. Sitting			Hrs Per Day
c. Standing			Hrs Per Day
d. Walking			Hrs Per Day
e. Climbing			Hrs Per Day
f. Kneeling			Hrs Per Day
g. Bending/Stooping			Hrs Per Day
h. Twisting			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day
j. Simple Grasping			Hrs Per Day
k. Fine Manipulation (includes keyboarding)			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day
o. Temp. Extremes			range in degrees F
p. High Humidity			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
r. Fumes/Dust (identify)			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day
t. Other (Describe)			

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis Due to Injury | 11. Other Disabling Conditions

12. Employee Advised to Resume Work?
☐ Yes, Date Advised ___/___/___ ☐ No

13. Employee Able to Perform Regular Work Described on Side A?
☐ Yes, If so ☐ Full-Time or ☐ Part-Time ___ Hrs Per Day
☐ No, If not, complete below:

Continuous	Intermittent	
#lbs.	#lbs.	Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		range in degrees F
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination | 16. Date of Next Appointment

17. Specialty | 18. Tax Identification Number

19. Physician's Signature | 20. Date

Form CA-17
Rev. Jan. 1997

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Duty Status Report

Save

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0103
Expires: 08-31-02

OWCP File Number (If known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)
Jones. Mary E.

2. Date of Injury (Month, day, yr.)
08/14/2003

3. Social Security No.
123-55-4444

4. Occupation
Security Guard

5. Describe How the Injury Occurred and State Parts of the Body Affected
She fell and bruised right knee.

6. The Employee Works
Hours Per Day 8 Days Per Week 5

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent		Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs. 15	#lbs. 25	3 Hrs Per Day	#lbs.	#lbs.	Hrs Per Day
b. Sitting	4	4	8 Hrs Per Day			Hrs Per Day
c. Standing	4	4	8 Hrs Per Day			Hrs Per Day
d. Walking	4	4	8 Hrs Per Day			Hrs Per Day
e. Climbing	1/2	1/2	8 Hrs Per Day			Hrs Per Day
f. Kneeling	1	2	8 Hrs Per Day			Hrs Per Day
g. Bending/Stooping	1	2	8 Hrs Per Day			Hrs Per Day
h. Twisting	1/2	1	8 Hrs Per Day			Hrs Per Day
i. Pulling/Pushing	1/2	1/2	8 Hrs Per Day			Hrs Per Day
j. Simple Grasping	3	5	8 Hrs Per Day			Hrs Per Day
k. Fine Manipulation (includes keyboarding)	2	4	8 Hrs Per Day			Hrs Per Day
l. Reaching above Shoulder	1/4	1	8 Hrs Per Day			Hrs Per Day
m. Driving a Vehicle (Specify)	1/2	2	8 Hrs Per Day			Hrs Per Day
n. Operating Machinery (Specify)	1/2	1/2	8 Hrs Per Day			Hrs Per Day
o. Temp. Extremes	5	5	30 range in degrees F			range in degrees F
p. High Humidity	0	0	8 Hrs Per Day			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	1/2	1	8 Hrs Per Day			Hrs Per Day
r. Fumes/Dust (identify)	5	3	8 Hrs Per Day			Hrs Per Day
s. Noise (Give dBA)	1	1	dBA Hrs Per Day			dBA Hrs Per Day
t. Other (Describe)						

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis Due to Injury

11. Other Disabling Conditions

12. Employee Advised to Resume Work?
☐ Yes, Date Advised ___/___/___ ☐ No

13. Employee Able to Perform Regular Work Described on Side A?
☐ Yes, If so ☐ Full-Time or ☐ Part-Time _____ Hrs Per Day
☐ No, If not, complete below:

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination

16. Date of Next Appointment

17. Speciality

18. Tax Identification Number

19. Physician's Signature

20. Date

Form CA-17
Rev. Jan. 1997

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE DATE

SIGNATURE DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE DATE

SIGNATURE DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME

GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME | SIGNATURE OF REPRESENTATIVE | TELEPHONE NUMBER | DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

GOVERNMENT AGENCY COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

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SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

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- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active _____
- ☐ Mil. Retire. _____
- ☐ Mil. Survivor _____
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

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SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

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PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

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THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224

FINANCIAL INSTITUTION COPY

1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

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- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

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- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

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PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

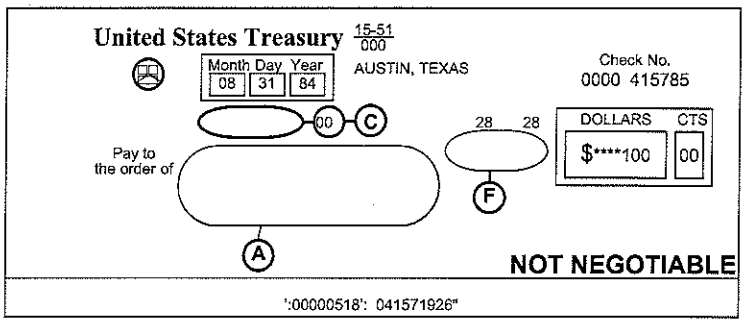
PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

- (A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.
- (C) Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.
- (F) Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

Claim for Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee — Last — First — Middle

OMB No. 1215-0103
Expires: 10/31/2008

b. Mailing Address (*Including City State, ZIP Code*)

c. OWCP File Number

d. Date of Injury
Month Day Year

e. Social Security Number

E-Mail Address (*Optional*)

f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

		Inclusive Date Range From	To	Intermittent?	
a. ☐	Leave without pay			☐ Yes ☐ No	*Go to Section 3*
b. ☐	Leave buy back			☐ Yes ☐ No	*Go to Section 3, and Complete Form CA-7b*
c. ☐	Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type:			☐ Yes ☐ No	*Go to Section 3*
d. ☐	Schedule Award (*Go to Section 4*)			If intermittent, complete Form CA-7a, Time Analysis Sheet	

SECTION 3 You must report **all** earnings from employment (**outside** your federal job); include any employment for which you received a salary, wages, income, sales commissions, piecework, or payment of **any** kind during the period(s) claimed in Section 2. Include self-employment, involvement in business enterprises, as well as service with the military forces. Fraudulent concealment of employment or failure to report income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you worked outside your federal job for the period(s) claimed in Section 2?***

☐ Yes — Name and Address of Business:

Name — Address — City — State — ZIP Code

☐ No *Go to section 4*

Dates Worked: — Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (*including spouse*):

Name	Social Security #	Date of Birth	Relationship	Living with you? Yes	No
				☐	☐
				☐	☐
				☐	☐

For dependents not living with you, complete items a and b below.

a. Are you making support payments for a dependent shown above? ☐ Yes ☐ No If Yes, support payments are made to:

Name — Address — City — State — ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

☐ Yes ☐ No	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment

c. Have you applied for or received payment under any Federal Retirement or Disability law?

☐ Yes ☐ No	Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
				☐ CSRS ☐ FERS ☐ SSA ☐ Other

SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

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 prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature _____ Date (*Mo., day, year*) _____

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury: Base Pay	Type _____	Type _____	Type _____
Date: _____ $_____ per _____	$_____ per _____	$_____ per _____	$_____ per _____
Grade: _____ Step: _____			
Date Employee Stopped Work:	Type _____	Type _____	Type _____
Date: _____ $_____ per _____	$_____ per _____	$_____ per _____	$_____ per _____
Grade: _____ Step: _____			

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? Yes ☐ No ☐

1. If Yes, circle scheduled days: ☐ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From _____ to _____							
From _____ to _____							

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

If No, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? ☐ No ☐ Yes Code _____

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Use Insurance? ☐ No ☐ Yes Class _____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan _____ *(Specify CSRS, FERS, Other)*

SECTION 11 Continuation of Pay (COP) Received (*Show inclusive dates*):

From _____ To _____

Intermittent? ☐ Yes — Complete Time Analysis Sheet, Form CA-7a ☐ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

			Intermittent?
Sick Leave From	_____	To _____	☐ Yes ☐ No
Annual Leave From	_____	To _____	☐ Yes ☐ No
Leave without Pay From	_____	To _____	☐ Yes ☐ No
Work From	_____	To _____	☐ Yes ☐ No

If intermittent, complete Form CA-7a, Time Analysis Sheet.

If leave buy back, also submit completed Form CA-7b.

SECTION 13 Did employee return to work? ☐ Yes ☐ No

If Yes, date _____

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain:

SECTION 14 Remarks:

SECTION 15 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature _____ Title _____ Date ___/___/___

(Agency Official)

Name of Agency _____

Date Claim Form Recieved from Employee ___/___/___

If OWCP needs specific pay information, the person who should be contacted is:

Name _____ Title _____

Telephone No. _____ Fax No. _____ E-Mail Address _____

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

EMPLOYEE (or person acting on the employee's behalf) - Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete sections 8 through 15 as directed and promptly forward the form OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd 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 who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present else- where on the form.

The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

Public Burden Statement

Public reporting burden forth is collection of information is estimated to average 13 minutes per response including the 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 this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are here by notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U. S .Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Claim for Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

SECTION 1 — **EMPLOYEE PORTION**

a. Name of Employee	Last	First	Middle	OMB No. 1215-0103
	Hilton	Janice	K	Expires: 10/31/2008

b. Mailing Address (*Including City State, ZIP Code*)
2358 W Hollywood Ct

c. OWCP File Number
[illegible]32505678

Dessertville AZ 92254

d. Date of Injury — Month Day Year: 02/05/2002

e. Social Security Number: 123-45-[illegible]3

E-Mail Address (*Optional*)

f. Telephone No./FAX No.
(1[illegible]87-4321
[illegible])457-2468

SECTION 2 Compensation is claimed for:

	Inclusive Date Range From	To	Intermittent?	
a. ☒ Leave without pay	04/02/2004	04/20/2004	☐ Yes ☒ No	*Go to Sectio[illegible]*
b. ☐ Leave buy back			☐ Yes ☐ No	*Go to Section 3, [illegible]Comp[illegible] Form CA-7b*
c. ☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type:			☐ Yes ☐ No	*Go to Section 3*
d. ☐ Schedule Award (*Go to Section 4*)			If intermit[illegible]omplete Form CA-7a, Time Analysi[illegible]et	

SECTION 3 You must report **all** earnings from employment (**outside** your fede[illegible]lude any[illegible]yment for[illegible]n you received a salary, wages, income, sales commissions, piecework, or payment of **any** kind during [illegible]eriod(s)[illegible]ned in Sec[illegible]. Inc[illegible] self-employment, involvement in business enterprises, as well as service with the military forces. Fraudulen[illegible]cealment o[illegible]loyment or [illegible]eport income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you [illegible]ked outside [illegible]r federal job [illegible]the period(s) claimed in Section 2?***

☐ Yes — Name and Address of Business:

☒ No — *Go to section 4*

Name | Address | City | State | ZIP Code

Dates Worked: | Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation [illegible]n h[illegible]iled for this [illegible]y?

☐ Yes *Complete Sections 5 through 7 and a Form S[illegible]199A, "[illegible]ect Deposit Sign-up"*

☐ No Has there been any change in your dependents[illegible] has yo[illegible]irect deposit information changed, or has there been a claim filed with U.S. Civil Service[illegible]ment, another f[illegible]ral retire[illegible]t or disability law, or with the Department of Veterans Affairs since your last CA-[illegible]

☐ Yes - *Complete Sections [illegible]ugh 7 [illegible]w S[illegible]199A to reflect change(s)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (*including spo[illegible]*)

Name	Social S[illegible]ty #	Date of Birth	Relationship	Living with you? Yes	No
Marvin Hilton	222-33-444[illegible]	01/01/2001	son	☒	☐
				☐	☐
				☐	☐

For dependents not living with you, complete items a and b below.

a. Are you making support paymen[illegible]r a d[illegible]ident shown above? ☐ Yes ☐ No If Yes, support payments are made to:

Name | Address | City | State | ZIP Code

b. Were supp[illegible]payments ordered by a [illegible]t? ☐ Yes ☐ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will [illegible]a claim[illegible]de against a 3rd party? ☐ Yes ☐ No

b. Have yo[illegible]ver appli[illegible]or rece[illegible]d disability benefits from the Department of Veterans Affairs?

☐ Yes ☐ No	[illegible]mber	Ful[illegible]ddress of VA Office Where Claim Filed	Nature of Disability and Monthly Payment

c. Have you applied for [illegible]rece[illegible]payment under any Federal Retirement or Disability law?

☐ Yes ☐ No	Claim Num[illegible]	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
				☐ CSRS ☐ FERS ☐ SSA ☐ Other

SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

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 prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature _____ Date (*Mo., day, year*) _____

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury: Base Pay	Type _____	Type _____	Type _____
Date: 02/05/2002 $ 33.33 per hr	$ _____ per _____	$ _____ per _____	$ _____ per _____
Grade: GS-14 Step: 6			
Date Employee Stopped Work:	Type _____	Type _____	Type _____
Date: 02/20/2002 $ 33.33 per hr	$ _____ per _____	$ _____ per _____	$ _____ per _____
Grade: GS-14 Step: 6			

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? Yes ☐ No ☐

1. If Yes, circle scheduled days: ☐ S ☒ M ☒ T ☒ W ☒ TH ☒ F ☐ S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From ____ to ____							
From ____ to ____							

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

If No, would position have afforded employment for 11 months but for injury? ☐ Yes ☐ No

SECTION 10 On date pay stopped, was employee enrolled in Federal Employees Health Benefits (FEHB) Program? ☐ No ☒ Yes Class _____ (D-Z only)

a. Health Benefits under the FEHBP? ☐ No ☒ Yes Code _____

b. Basic Life Insurance? ☐ No ☒ Yes

Retirement System? ☐ No ☒ Yes Plan _____ (Specify CSRS, FERS, Other)

SECTION 11 Continuation of Pay (COP) Received (Show inclusive dates)

From _____ To _____

Intermittent? ☐ Yes — Complete Time Analysis Sheet, Form CA-7a ☐ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed.

			Intermittent?	
Sick Leave	From _____	To _____	☐ Yes ☐ No	If intermittent, complete Form CA-7a, Time Analysis Sheet.
Annual Leave	From _____	To _____	☐ Yes ☐ No	
Leave without Pay	From 02/02/2004	04/20/2004	☐ Yes ☒ No	If leave buy back, also submit completed Form CA-7b.
Work	From _____	To _____	☐ Yes ☐ No	

SECTION 13 Did employee return to work? ☐ Yes ☐ No

If Yes, date _____

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain: _____

SECTION Remarks _____

SECTION 15 Employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section , Remarks, above.

Signature George L. Jefferson Title Supervisor Date 2/22/2004
(Agency Official)

Name of Agency _____

Date Claim Form Recieved from Employee / /

If OWCP needs specific pay information, the person who should be contacted is:

Name _____ Title _____

Telephone No. _____ Fax No. _____ E-Mail Address _____

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.[illegible]6.

EMPLOYEE (or person acting on the employee's behalf) - Complete sections 1 through [illegible]as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete section[illegible]nrough 15[illegible]directed and promptly forward the form OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification a[illegible]olained be[illegible].

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permaner[illegible]airment to a m[illegible]er or function of the body.
5. List your dependents	Your wife or husband is[illegible]ependent[illegible]e or she l[illegible]with you. A child is a dependent if he, or sh[illegible]ther lives w[illegible]you or receiv[illegible]support payments from you, and he or she:[illegible]s under 18, o[illegible]is between 18 and 23 and is a full-time student, or 3) is incap[illegible]of self-s[illegible]ort due to physical or mental disability.
6a. Was/will there be a claim made against 3rd party?	A third party[illegible]ndividual[illegible]anization (other than the injured employee or the Federal g[illegible]nt) who i[illegible]le for the injury. For instance, the driver of a vehicle causing[illegible]ent in wh[illegible]n employee is injured, the owner of a building where u[illegible]afe[illegible]itions ca[illegible]an employee to fall, and a manufacturer who gave impropr[illegible]nstru[illegible]s for the use of a chemical to which an employee is exposed, could a[illegible]e cor[illegible]ed third parties to the injury.
8. Additional Pay	[illegible]" includ[illegible]night differential, Sunday premium, holiday premium, and[illegible]othe[illegible]such[illegible]s hazardous duty or "dirty work" pay) regularly receiv[illegible]the em[illegible]ut does not include pay for overtime. If the amount of such p[illegible]eries from p[illegible]period to pay period (as in the case of holiday premium or[illegible]ating shift), then the total amount of such pay earned during the year immediat[illegible]ior to the date of injury or the date the employee stopped [illegible]whichever i[illegible]eater) should be reported.
11. Continuation of pay (COP) received	If[illegible]injury wa[illegible]not a traumatic injury reported on Form CA-1, this item does [illegible]apply.
14. Rema[illegible]	[illegible]This space is used to provide relevant information which is not present [illegible]e- where on the form.

The authori[illegible]esting this info[illegible]ation is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested[illegible]ormation is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance[illegible]h the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requeste[illegible]nfo[illegible]n may delay the process, or result in an unfavorable decision or a reduced benefit.

Public Burden Statement

Public reporting burden forth is collection of information is estimated to average 13 minutes per response including the 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 this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are here by notified that: (1) The Federal Employees' Compensation Act, as amended a[illegible] extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' [illegible]ompensation Programs of the U. S .Department of Labor, which receives and maintai[illegible] personal information on claimants and their immediate families. (2) Informati[illegible] which the [illegible]ffice has will be used to determine eligibility for and the amount of bene[illegible] payable [illegible]er the FECA, and may be verified through computer matches or other appro[illegible]e m[illegible]ns. (3) Information may be given to the Federal agency which employed the cla[illegible]nt at the time of injury in order to verify statements made, answer questions concerning the [illegible]us of the claim, verify billing, and to consider issues relating to retention, rehire, or ot[illegible] relevant matters. (4) Information may also be given to [illegible]r Federal agencies, other government entities, and to private-sector agencies and/or [illegible]loyers as part of rehabilitative and other return-to-work programs and services. (5) Informatic[illegible]ay be disclosed to physicians and other healthcare pr[illegible]se in p[illegible]iding [illegible]atment or medical/vocational rehabilitation, making ev[illegible]ations fo[illegible]e Office, [illegible] other purposes related to the medical manageme[illegible]f the claim. (6) Information may be given to Federal, state and local agencies for la[illegible]forcemen[illegible]rposes, to obtain information relevant to a decision under the FECA, to de[illegible]ine [illegible]ether benefits are being paid properly, including whether prohibi[illegible]dual pay[illegible]s are being made, and, where appropriate, to pursue salary/admin[illegible]e offset a[illegible]ebt collection actions required or permitted by the FECA and/or the De[illegible] Co[illegible]tion Act. (7) Disclosure of the claimant's social security number (SSN) or tax ide[illegible]fyi[illegible]mber (TIN) on this form is mandatory. The SSN and/or TIN, and other informat[illegible] maini[illegible]d by the Office, may be used for identification, to suppo[illegible]llection et[illegible]ts carri[illegible] on by the Federal government, and for other purposes re[illegible]d o[illegible]rize[illegible]y law. (8) Failure to disclose all requested information may delay the pr[illegible]sing o[illegible]n or the payment of benefits, or may result in an unfavorable decisio[illegible]educed level of benefits.

Note: This n[illegible]e a[illegible] all forms [illegible]questing information that you might receive from the Offic[illegible] connec[illegible] the processing and adjudication of the claim you filed under the [illegible]CA.

Time Analysis Form

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

Employee Statement - Please carefully read instructions on reverse *before* filling out this form.

1. Name of Employee: *(Last, First, Middle)*	2. SSN	3. OWCP File Number

4. Period Covered by This Form:
From: _____ / _____ / _____ To: _____ / _____ / _____

5. Total Hours Claimed
for LWOP: _____
for Leave BuyBack: _____

6. In "Type of Leave Used" column, use codes "S" Sick, "A" = Annual, "O" = Other. If compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours				Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Hol	Leave		
Totals							

Signature of Claimant _____ Date Signed _____

7. **Agency Statement/Certification:** I certify the above is accurate, except as follows:

Signature of Agency Official _____ Date Signed _____

Form CA 7a
June 1996

Instructions for Completing Form CA-7A
Time Analysis

General: This form is used when claiming FECA compensation, including repurchase of paid leave. It must be used when claiming compensation for more than one consecutive period of leave.

Instructions for Employee:

Blocks 1, 2, and 3: Self-explanatory.

Block 4: Indicate beginning and ending dates covered by this form. These must be the same as on Forms CA-7 and CA-7b.

Block 5: If claiming compensation for any dates detailed in block 4, state total number of hours claimed for leave without pay and total number of hours of leave. This should be at least 10 hours unless this is your final claim.

Block 6:

1st Column:	Show full date.
2nd Column:	For each date noted in column 1, state "Y" if you are claiming compensation for that date and "N" if you are not.
3rd, 4th, 5th and 6th Columns:	Show the number of hours of LWOP, number of hours worked, paid holiday hours, and number of hours of paid leave.
7th Column:	Using the legend provided, indicate the type of leave used.
8th Column:	State the reason you were off work. For each date for which compensation is claimed, there must be medical evidence supporting entitlement.

Sign and Date Form and Submit to the Appropriate Agency Official.

Instructions for Employing Agency:

Block 7: Verify accuracy of hours and status for each date listed. If challenging entitlement for any date, attempt to resolve discrepancies prior to submitting claim to OWCP. If discrepancy cannot be resolved, indicate the specific basis for the challenge in the space provided.

Leave Buy Back (LBB) Worksheet/ Certification and Election

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

Employee Statement - Please carefully read instructions on pages 3 and 4 *before* filling out this form.

A. Name of Employee: *(Last, First, Middle)*	B. OWCP File Number:
C. Social Security Number:	

D. Period for Which Compensation is Claimed to Repurchase Leave

From: _____ / _____ / _____ To: _____ / _____ / _____

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate *(excluding overtime)*

- Date of Injury _____ / _____ / _____ $ _____
- Date Stopped Work _____ / _____ / _____ $ _____
- Date of Recurrence _____ / _____ / _____ $ _____

Enter the greatest amount and the effective date of that amount on line 1. 1. _____

_____ / _____ / _____
(effective date)

B. Additions to Base Pay:
If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 ÷ by 52.

- Night Differential 2. _____
- Sunday Premium 3. _____
- Subsistence/Quarters 4. _____
- Other *(Specify)* 5. _____

C. Total Weekly Payrate *(Add lines 1 through 5)* 6. _____

D. Compensation Rate *(Circle either 2/3 or 3/4)* 7. 2/3 3/4

E. Total Hours Claimed on CA-7a 8. _____

F. Total Hours Worked per Week 9. _____

G. Formula ***(for FECA Entitlement)***

$ _____ (Weekly Payrate See Line 6) X _____ (Compensation Rate See Line 7) X _____ (Hours See Line 8) ÷ _____ (Hours Wkd/Wk See Line 9) = 10. $ _____

II. Agency Certification:

H. Total Amount Due Agency to Repurchase Leave 11. $ _____

I. Estimate of FECA Entitlement *(See Line 10)* 12. $ _____

J. Balance Due Agency from Employee *(Line H minus Line I)* 13. $ _____

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

_____ _____

(Signature of Agency Official) (Title/Position)

Phone No _____ Date Signed: _____

Employing Agency Address for Check: _____

_____

_____

III. Employee Claim:

_____ **K.** I hereby elect **not** to repurchase the leave used at this time.

_____ **L.** I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my Job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above. OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

_____ _____

(Signature of Claimant) (Date Signed)

Instructions Form CA-7B
Leave Buy Back Worksheet

This form is intended to accompany Form CA-7, *Claim for Compensation,* when the employee is claiming leave buy back.

Things to Know About Leave Buy Back:

When an employee uses their sick or annual leave to cover an injury-related absence from work, they may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 3/4 with 1 or more dependents. The agency pays leave at 100% of salary. In order for leave to be reinstated, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency.

The employee's pay status must be changed to LWOP in order for compensation to be paid. Leave is not earned while in LWOP. Also, contributions to the Thrift Savings Plan (TSP) are not made during LWOP. Therefore, the repurchase of leave may result in a reduction in an employee's leave and/or TSP balance. Consult your personnel office to learn how the change to LWOP would effect you.

When a Leave Buy Back (LBB) payment is made during the same year that leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. Where leave repurchase is not completed during the same year in which leave is used, the employee may not adjust their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Further questions regarding tax implications of LBB should be addressed to the IRS.

A claimant may not repurchase leave used during a period they were eligible for COP.

When disability does not exceed 14 days beyond the COP period, 3 day LWOP must be charged before compensation can be paid. If leave was used for this period, compensation can not be paid for the 3 days, but the claimant will have to pay back leave paid during the 3 days to repurchase the leave.

Instructions to the Employee:

Please submit a claim for a minimum of 10 hours unless no further claim is anticipated. Medical documentation must be provided for all dates claimed.

1. Complete the Form CA-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete Form CA-7a following the instructions for completing that form.

2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.

3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, arid the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.

    a. If the total amount of FECA benefits estimated by the agency is not more than 1 0% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.

    b. If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Off ice will offer you a new election with the correct amount of FECA benefits payable,

Instructions to the Agency:

Items A through D (top of form) are self-explanatory.

Section I. Agency Estimate of FECA Entitlement:

Item A: Enter all three pay rate types and effective dates if applicable. Choose the greatest amount of the three and enter the amount and effective date in Line 1. A recurrent pay rate should only be used if: (1) the employee stops work more than 6 months following their first return to regular, full time duty and (2) the loss of time is due to disability rather than medical examinations or treatment.

For unusual situations, please refer to Payrate Desk Aid.

Item B: If the employee works a regular schedule, enter the differentials earned weekly. If an irregular schedule, give the total amount earned for the year prior to the date in Line 1 divided by the number of weeks worked in that year.

Please refer to Payrate Desk Aid for guidance on inclusions and exclusions. If in doubt, consult a Claims Examiner.

Item C: Add lines 1 through 5 and enter the total in Line 6.

Item D: Circle the appropriate rate: 2/3 for employees without dependents; 3/4 with dependents. Dependents include: spouse; children under 18 living with or supported by the employee; children under 23 in school fuil time; children over 18 incapable of self support; and parents wholly supported by the employee.

Item E: Enter the total hours *claimed,* from Form CA-7a.

Item F: Enter the total hours in the employee's normal work week.

Item G: Formula for FECA Entitlement. Use this formula to calculate estimate of FECA entitlement and enter the result in Line 10.

> *Example of computation:* The weekly pay from line 6 is $574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:
>
> $574.00 x 3/4 x 82 hours ÷ 40 hours = $882.52

Section II. Agency Certification:

Item H & I are self-explanatory. For Line J, subtract Line I from Line H.

Sign and date, and advise the employee of the amount they owe to the agency.

Section III. Employee Claim:

If the employee elects not to repurchase the leave, retain the form in the agency files. If the employee elects to repurchase the leave, submit all claim documents (CA-7, CA-7a & CA-7b) plus any medical documentation to OWCP for processing.

Attending Physician's Report

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

Record of Examination

1. Patient's name Last First Middle	2. Date of injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 08-31-02

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #13 ☐ Yes ☐ No	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name	Specialty
Address	27. What was the reason for this referral?
City State ZIP	☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician	30. Tax ID Number
Address	31. Do you specialize? ☐ Yes ☐ No
City State ZIP	32. If yes, indicate specialty

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE. THIS INFORMATION IS REQUIRED TO OBTAIN OR RETAIN A BENEFIT (5 USC 8101 et seq.).

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, 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 these estimates or any other aspect of 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, D.C. 20210

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

Attending Physician's Report

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo, day yr.	3. OWCP File Number	OMB No. 1215-0103 Expires: 10-31-08
DAY	DONALD	L	02/10/1994	310114444	

4. What history of injury (including disease) did patient give you?

EMPLOYEE FELL FROM SCAFFOLD INJURYING RIGHT ANKLE.

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

SPRAINED RIGHT ANKLE

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☒ Yes ☐ No

9. Did injury require hospitalization? If no, go to item # 13	10. Date of admission mo, day yr.	11. Date of discharge mo, day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25)
☐ Yes ☒ No			☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo, day yr.	15. Date(s) of treatment mo, day yr.	mo, day yr.	mo, day yr.	16. Date of discharge from treatment mo, day yr.
02/10/1994	02/10/1994			

17. Period of total disability From mo. day yr. Thru mo, day yr.	18. Period of Partial Disability From mo. day yr. Thru	mo. day yr.	19. Date employee able to resume light work mo, day yr.
	02/10/1994	03/12/1994	02/11/1994

20. Date employee is able to resume regular work mo, day yr.	21. Has employee been advised that he/she can return to work?	22. If yes, on what date was he/she advised? mo, day yr.
03/13/1994	☒ Yes ☐ No	03/12/1994

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☒ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name / Address / City State ZIP	Specialty / 27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date 08/14/2007

29. Name of Physician / Address / City State ZIP	30. Tax ID Number / 31. Do you specialize? ☐ Yes ☐ No / 32. If yes, indicate specialty