OCCUPATIONAL DISEASE

An occupational disease is defined as a condition produced in the work environment over a period longer than one work day or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment.

The injured employee, or someone acting on his or her behalf, should give notice of occupational disease on Form CA-2. (Such notice may be provided by the supervisor as well.) The supervisor should issue to the employee two copies of the appropriate checklist, Form CA-35a-h, for the disease claimed (To facilitate submittal of evidence, specific checklists have been devised for various conditions). The supervisor should also explain the need for detailed information to the employee and advise him or her to furnish supporting medical and factual information requested on the checklist. If possible, this information should be submitted with the form. Upon receiving Form CA-2, 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-2, including a telephone number in case OWCP personnel have questions about the claim.

(3) Sign and return to the employee the receipt attached to Form CA-2 and give a copy of the form to the employee if requested;

(4) Review the employee's portion of the form and provide comments on the employee's statement requested in (5);

(5) Prepare a supporting statement to include exposure data, test results, copies of reports of previous medical examinations, and/or witness statements, depending on the nature of the case. The checklist may be used to coordinate compilation of material by agency personnel, including compensation specialists and safety and health officers;

(6) Advise the employee of the right to elect sick or annual leave or leave without pay, pending adjudication of the claim.

(7) Forward the Package to the DHRC-I for processing.

Notice of Occupational Disease and Claim for Compensation

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

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
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

5. Home telephone ( )

6. Grade as of date of last exposure Level Step

7. Employee's home mailing address (Include city, state, and ZIP code)

6. Dependents
- ☐ Wife, Husband
- ☐ Children under 18 years
- ☐ Other

Claim Information

9. Employee's occupation

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (Include city, State, and ZIP code)

11. Date you first became aware of disease or illness MO. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment MO. Day Yr.

13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness

OWCP Use - NOI Code
b. Type code | c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain **the reason for the** delay.

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with 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 other benefits provided by the Federal Employees' Compensation Act.

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

Have your supervisor complete the receipt attached to this form and return it lo you for your records.

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.

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

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (Include city, state, and ZIP Code)

OWCP Agency Code

OSHA Site Code

ZIP Code

20. Employee's duty station (Street address and ZIP Code)

ZIP Code

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

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

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

24. First dat medical care received Day Yr.

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

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

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

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, 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)

Signature of Supervisor

Date

Supervisor's Title

Office phone

INSTRUCTIONS FOR COMPLETING FORM CA-2

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. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Deailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible 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 must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. 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).

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

23. 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.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

32. *Employee's Retirement* Coverage.
Indicate which retirement system the employee is covered under.

33. Was the 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 disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupational 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, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit 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.

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

An employee may use sick or annual leave rather than LWOP while disabled. The employae 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.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

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 (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) The 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) The information may also be given to Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and servies. (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. (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.

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Notice of Occupational Disease And Claim for Compensation

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

Employee: Please complete all boxes 1 – 18 below. Do not complete shaded areas.
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
3. Date of birth Mo. Day Yr. 06/30/54	4. Sex M	5. Home telephone (703) 222-2222	6. Grade as of date of last exposure Level 12 Step 01

7. Employee's home mailing address (include city, state, and ZIP code)
679 Bean Street
Anywhere, US 22222

8. Dependents
☒ Wife, Husband
☐ Children under 18 years
☐ Other

Claim Information

9. Employee's occupation
Human Resources Specialist

a. Organization Code

10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP code) 8725 John J. Kingman Rd, Ft. Belvoir, VA 22060

11. Date you first became aware of disease or illness
Mo. 01 Day 29 Yr. 2004

12. Date you first realized the disease or illness was caused or aggravated by your employment
Mo. 02 Day 03 Yr. 2004

13. Explain the relationship to your employment, and why you came to this realization. **Large amount of typing required for the position and past positions as a federal employee. Medical test confirm that is was related to federal employment.**

14. Nature of disease or illness
Bilateral carpal tunnel syndrome

OWCP Nat'l Occ. Code

b. Type code c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after the date shown above in item #12, explain the reason for the delay. **Waiting confirm diagnosis from treating physician.**

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

Not applicable

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Not applicable

Employee Signature

18. I certify, under penalty of law, that the disease or illness describes above was the result of my employment with 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 herby claim medical treatment if needed, and other benefits provided by the Federal Employees' Compensation Act.

Signature of employee or person acting on his/her behalf _____ Date 01/29/04

Have your supervisor complete the receipt attached to this form and return it to you for your records.

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.

Official Supervisor's Report of Occupational Disease: Please complete information below

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and ZIP code)

Injury Compensation Center, DHRC-I
8725 John J. Kingman Road, Stop 6231
Ft. Belvoir, VA 22060

OWCP Agency Code

OSHA Site Code

20. Employee's duty station Street address and ZIP Code)
HQ, 8725 John J. Kingman Road, Stop 6231, Ft. Belvoir, 22060

21. Regular work hours: ☒ AM From: 07:00 To: 03:30 ☒ PM ☐ AM ☐ PM

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

23. Name and address of physician first providing care (include city, state, and ZIP code)

Dr. Henry Bombay
123 Hope Street
Anytown, US 11111

24. First date Medical care received: Mo. 02 Day 03 Yr. 2004

25. Do medical reports show employee is Disabled for work? ☐ Yes ☒ No

26. Date employee first reported condition to supervisor: Mo. 02 Day 03 Yr. 2004

27. Date and hour employee stopped work: Mo. Day Yr. **N/A** Time ☐ AM ☐ PM

28. Date and hour employee's pay stopped: Mo. Day Yr. Time ☐ AM ☐ PM

29. Date employee was last exposed to conditions alleged to have caused disease or illness: Mo. **02** Day **03** Yr. **2004**

30. Date returned to work: Mo. Day Yr. Time ☐ AM ☐ PM

31. If employee has returned to work and work assignment has changed, describe new duties
Employee's allows for rest breaks. Employee is able to monitor on work.

32. Was injury caused by third party? ☐ Yes ☒ No if "No", go to item 34.

33. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

34. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, 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)

Signature of Supervisor

Date

Supervisor's Title

Office Phone ( )

Evidence Required In Support of a Claim for Occupational Disease

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

All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job factors.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment, b. History given by you. c. Detailed description of findings, d. Results of all diagnostic tests, e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.	

FROM EMPLOYING AGENCY	✔
5. Review and comment on employee's statement provided in response to Item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed to let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible. Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rately adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. . Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

Evidence Required in Support of a Claim for Work-Related Hearing Loss

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

IF YOU ARE FILING A CLAIM FOR HEARING LOSS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.	
2. For each job title, describe source of noise, number of hours of exposure per day, and use of any safety devices to protect against noise exposure. State when safety devices were provided.	
3. Give history of any previous ear or hearing problems.	
4. Describe any hobbies which involve exposure to loud noise.	
5. If you are no longer exposed to hazardous noise at work, give the date you were last exposed.	
6. If you have been examined or treated by a doctor for an ear or hearing problem, provide a medical report and audiograms.	
7. State whether a claim for workers' compensation benefits for this or any other condition affecting ears or hearing was ever filed. If so, give date of claim, name and address where filed, and benefits received.	
8- Give the date you first noticed your hearing loss.	
Give date you first related hearing loss to employment, and reason why.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the employee's statement in response to questions 1-5.	
10. Describe all work-related exposure to hazardous noise, including: a. Locations of job sites. b. Nature of exposure to noise (machinery, etc.) c. Decibel and frequency level (noise survey report) for each job site. d. Period of exposure, hours per day, days per week. e. Type of ear protection provided.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Job sheet and employment record. c. All medical examinations pertaining to hearing or ear problems, including preemployment examination and all audiograms.	
12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this numoer on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensatiion benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible*? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate[1]? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rately adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees Notice of Occupational Disease and Claim for Comepnsation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to froward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

Evidence Required in Support of A Claim for Asbestos-Related Illness

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

If you are filing a claim based on exposure to asbestos, use this checklist to identify the information needed from you and your employing agency. All of the following information should be submitted with Form CA-2, Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service (see attached questionnaire.)	
2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days per week exposed, and the types and frequency of safety precautions (mask, respirator, etc.) used (see attached questionnaire).	
3. Describe any exposure you have had to other toxic substances. If none, state "None".	
4. Describe any breathing or lung problems you have had in the past and treatment received (see attached questionnaire).	
5. Give your smoking history to include amount per day, and years (dates) you have smoked (see attached questionnaire).	
6. Submit a report from your physician, including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.	
7. Give the date you first consulted a physician regarding respiratory or asbestos-related disease.	
8. Submit reports of examination, treatment or hospitalization for any previous similar condition or pulmonary problem.	

FROM EMPLOYING AGENCY	V*
9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.	
10. Provide exposure data, including air sample surveys or statements of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fiber/cc time weighted average. Also report concentrations of other pollutants and chemicals (see attached questionnaire).	
11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements for last job held. c. Job sheet and employment record, d. Pertinent dispensary records. e. Most recent SF-50, Notification of Personnel Action. f. Laboratory test results and chest x-ray reports on file.	
13. Describe safety regulations and protective devices in use by employee, with period and frequency of use.	

Notice to Employees Filing Claim for Occupational Disease

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The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employee's Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (0PM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

Notice to Compensation Specialists and Supervisors

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner Identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file *a* claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence requiredMn support of the claim. One checklist is for the employee to mark and return with the complete package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

PART A TO BE COMPLETED BY CLAIMANT

In order to determine If you are eligible for benefits, please provide the following information using your best estimates. If you run out of space, use a separate piece of paper and attach it to this form. Submit the form to your current (or last) employing agency. If the facility is no longer active, submit the statement to OWCP.

1. Employment History: Please include all employers, both Federal and non-Federal, your job titles, the work you performed, and the period you held each job. (Include military service).

	Employer (Agency)	Job Title	Work Performed	Period	Fed. Civil Service? (Yes/No)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

II. Exposure History: Please describe all exposure to asbestos and other toxic materials in your employment. Include period of employment, type of exposure, number of hours exposed per workday and description of safety precautions used while working.

a. Asbestos: For "type of exposure" indicate whether exposure was heavy, medium or light:

Heavy - Visible airborne asbestos particles were evident.

Medium - Asbestos dust was visible on floors and work surfaces.

Light - No dust visible, but asbestos was in use.

	Period	Type of Exposure (H, M, L)	Exposure Hrs/Day	Safety Precautions Used
1.				
2.				
3.				
4.				
5.				

b. Toxic Chemicals/Dust

	Period	Material Exposed to:	Exposure Hrs/Day	Safety Precautions Used
1.				
2.				
3.				
4.				
5.				

(PLEASE CONTINUE ON REVERSE SIDE)

Evidence Required in Support of a Claim for Work-Related Coronary/Vascular Condition

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

IF YOU ARE FILING A CLAIM FOR CORONARY OR VASCULAR CONDITIONS (for example: heart attack, stroke, hypertension). THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
5. Provide a medical report from your physician which includes: a. Dates of examination and treatment, b. History given by you. c. Family history and other risk factors, d. Detailed description of findings, e. Copies of all diagnostic test results, f. Diagnosis. g. The clinical course of treatment followed. h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in Item no. 1 above.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements in response to questions 1-5.	
7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertienent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

III. Medical History: Describe your medical history and include any treatment for heart, lung and other major health problems.

Have you ever had:	Yes	No	If Yes, explain	Dates
1. Heart Problems?	☐	☐		
2. Lung Problems?	☐	☐		
3. Other Major Problems?	☐	☐		

IV. Smoking History: Describe your smoking history, including dates you smoked, amount of material smoked per day, and type of material smoked.

Have you ever smoked:	Yes	No	If Yes, amount	No. of years	Date stopped	Dates
1. Cigarettes?	☐	☐				
2. Pipe?	☐	☐				
3. Cigars?	☐	☐				

PART B TO BE COMPLETED BY EMPLOYING AGENCY

Using the categories shown below, please complete the chart at the bottom of the page with reference to each Federal job held by this employee,

a. Nature of Exposure:

Primary - Normal duties required actual manipulation of asbestos and/or asbestos-related products and generated dust.

Secondary - Normal duties regularly involved work alongside others primarily exposed or in confined spaces.

Intermittent - Normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated.

Environmental - Normal duties were performed at a location where asbestos was used but the individual had no normal exposure in excess of ambient levels.

b. Degree of Exposure:

Heavy - Asbestos dust was usually visible in the air.

Medium - Asbestos dust was generally visible on work surfaces but did not cloud the air.

Light - Asbestos was used in work area but was generally not visible (although detectable).

Ambient - Asbestos levels did not exceed normal levels in the air outside of work spaces.

c. Frequency of Exposure: Hours per day.

Job Title	Period		Asbestos Exposure			Other Chemical or Dust Exposure				
	From	To	Nature	Degree	Frequency	Material	Nature	Degree	Frequency	Fiber/cc
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										

irU.S. GPO: 1988—202-081

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

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Evidence Required in Support of a Claim for Work-Related Skin Diease

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

IF YOU ARE FILING A CLAIM FOR A SKIN CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be sumitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✔
1. Give a detailed description of employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure.	
3. Describe any previous skin conditions from the time they began through the present.	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions.	
5. Attach or forward a medical report from your current physician to include: a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in Item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure. g. Work restrictions caused by the condition.	

FROM EMPLOYING AGENCY	✔
6. Review and comment on the employee's statements provided in response to questions 1-5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Copies of all physical examinations on file. e. Most recent SF-50, Notification of Personnel Action.	

Evidence Required in Support of a Claim for Work-Related Pulmonary Illness (not asbestosis)

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

IF YOU ARE FILING A CLAIM FOR PULMONARY CONDITION NOT RELATED TO EXPOSURE TO ASBESTOS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	^
1. Describe the work conditions which caused or aggravated your pulmonary condition; include types of irritants, dates of exposure and hours per day. Describe any safety measures taken..	
2. Explain the development of the present pulmonary condition and treatment from its beginning..	
3. Give your smoking history to include amounts and years (dates) you smoked.	
4. Give the history of previous pulmonary conditions: include dates and nature of illness, and treatment records from all physicians and hospitals where you were treated.	
5. Attach or forward a medical report which includes the following items: a. Dates of examination and treatment, b. History given by you. c. Detailed description of findings, d. Results of all diagnostic tests, e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may have and the factors of employment listed in Item no. 1.	

FROM EMPLOYING AGENCY	V*
6. Review and comment on employee's statement provided in response to questions 1-5. Give periods, degree and nature of exposure. Explain safety precautions. Give full details of any tests which were made to determine the concentration of irritants. Have other employees been similiarly affected?	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c> Preemployment medical examination and any other pertinent medical records. d. Most recent SF-50, Notification of Personnel Action.	

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

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Evidence Required in Support of a Claim for Work-Related Psychiatric Illness

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

IF YOU ARE FILING A CLAIM FOR A PSYCHIATRIC CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed chronological description of particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2, Describe the progress and development of the work-related condition from its beginning.	
3, Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✓
7. Review and comment on the employee's statements provided in response to questions 1-5. Submit statements from witnesses, if appropriate.	
8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

MEDICAL REPORT FOR PSYCHIATRIC CLAIM

You should submit a medical report from your physician which includes

a History of onset of illness
b Social and family history
c Detailed description of your work situation and identification of the specific work factors contributing to your emotional or psychiatric condition
d Review of any non-industrial stress situations
e Mental status examination, with pertinent findings
f Results of psychological and personality testing
g Diagnosis according to DSM lll
h Clinical course of treatment followed
i Prognosis with estimate of when you will be able to return to work
j Physician's opinion, with reasons for such opinion, as to whether, how and which factors of your employment caused, aggravated, precipitated, or accelerated your disability
k An assessment of your current condition, with specific details on how you can or cannot function in daily activities, including a discussion of any limitations you may have in your ability to give or take supervision, cooperate with others, work under deadlines, or any other pertinent factors which may effect your work capacity

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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HINTS Are your statements legible' Would your statements make sense to someone who has never done you- job? Do your statements answer the questions'? Are your statements complete and accurate"? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED Reports on medical forms such as Form CA-20, are rarely adequate in occupational disease cases

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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Wnevever an employee wants to file a claim for occupational disease or illness, please give him or her

1 Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2 Two copies of the checklist describing evidence required in support of the claim One checklist is for the employee to mark and return with the completed package The second checklist is for the employee to take to the physician

In addition, to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days Statements and documents required from the agency should be submitted with the CA-2 whenever possible Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending If pending, please give the enticipated mailing date Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions

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Evidence Required in Support of A Claim for Work-Related Carpal Tunnel Syndrome

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

If you are claiming that your carpal tunnel or wrist problems are due to your job, use this checklist to identify the specific information needed from you and your employing agency to make a decision on the claim. All of the following information should be submitted with Form CA-2. Please return the checklist with statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	V*	FROM EMPLOYING AGENCY	^0
1. Prepare a statement giving the following information:		1. Review the employee's statement, giving the following information:	
a. Provide an outline of your work history, including non-Federal employment and military service. For each job held, give your job title, agency/company name, and dates (period) of employment.		a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.	
b. For each job title, describe duties which required exertion with or repeated movement of the wrist or hand. Describe nature and frequency of motions required, and average number of hours a day/week you did such work.		b. Provide a day-to-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.	
c. Describe hobbies, physical fitness or other activities outside of work which also involved exertion or repeated motions of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.		c. Give date employee entered on duty in job requiring above duties. Also give the effective date(s) and description^) of any changes in work assignments due to employee's condition and indicate whether duty changes resulted in changes in pay.	
d. If you have ever had an injury to the hand/arm/wrist, or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist, from/since birth, describe the injury or condition, and state when injury occurred or condition was found.		2. Send us copies of employee's:	☐
e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected, when, you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.	☐	a. SF-171 , Application for Employment;	
2. Ask all doctors who treated you to send us a copy of reports or notes describing the condition, testing, and treatment given.	☐	b. Position description with physical requirements for last job held;	
		c. All available medical records, including report of pre-employment examination;	
		d. SF-50S or equivalent documents for changes in assignment/pay due to condition.	

3. Ask the doctor currently treating your condition to provide a detailed current medical report to include the following specifics:

a. Dates of examinations;

b. Complete medical history of condition;

c. Medical diagnosis of condition;

d. Findings and test results, specifically including: results of Phalen's and Tinel's Sign tests; physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence; results of nerve conduction velocity, and electromyographic testing;

e. Treatment to date and prognosis;

f. Reasoned opinion explaining any causal relationship between the condition and your Federal civilian job.

It is MOST IMPORTANT that the doctor provide opinion as to the likely nature of the physical effects attributable to specified duties of your Federal job, and explain the medical reasoning which supports the opinion as to cause.

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

Form CA-35H
October 1987

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