RECURRENCE

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

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

Notice of Recurrence

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

Employee: Complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0167
Expires: 05-31-02

Part A - Employee

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. OWCP file number for original injury
4. Date of birth Mo. Day Yr.
5. Sex ☐ Male ☐ Female
6. Home telephone ( )
7. Home mailing address (include city, state, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other
9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)
10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
11. Date and Hour of original injury (mo., day, year)
12. Date and Hour of recurrence (mo., day, year)
13. Date and Hour stopped work after recurrence (mo., day, year)
14. Date and Hour pay stopped after recurrence (mo., day, year)
15. Date and Hour returned to work (mo., day, year)
    - ☐ Medical Treatment Only
    - ☐ Time Loss From Work
17. Date of first medical treatment following recurrence (mo., day, year)
18. Name and address of treating physician
19. After returning to work following the original injury, were you in any way limited in performing your usual duties? ☐ Yes ☐ No
    (If so, explain. Also state how long these limitations continued.)
20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the Federal Employees' Compensation Act (FECA), or who knowingly accepts compensation to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee
24. Date (mo., day, year)

Part B - Federal Employing Agency

25. Name and address of reporting office (include city, state, and ZIP Code) | OWCP Agency Code

ZIP Code | OSHA Site Code

26. Employee's duty station (street address and ZIP Code)

27. Date of first return to FULL-TIME REGULAR duty following original injury
Mo. Day Yr.

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

29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

30. Date of injury Mo. Day Yr.

31. Date of recurrence Mo. Day Yr.

32. Date stopped work after recurrence Mo. Day Yr. Time ☐ a.m. ☐ p.m.

33. Date pay stopped after recurrence Mo. Day Yr.

34. Dates COP paid for recurrence From Mo. Day Yr. To

35. Date returned to work after recurrence Mo. Day Yr. Time ☐ a.m. ☐ p.m.

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☐ No

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? ☐ Yes ☐ No

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation?
☐ Yes ☐ No If so, provide full details.

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.

40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

A supervisor or compensation specialist 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.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence) | 42. Title | 43. Work phone ( ) | 44. Date (mo., day, year)

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

   $ _____ per _____

5. Do you claim compensation for lost wages? ☐ Yes ☐ No

   If so, for what period? _____ through _____

6. Have you received any pay during the period claimed? ☐ Yes ☐ No

   If so, how much and from what source? _____

Section 8101, et seq., Title 5 to the U.S. Code authorizes collection of this information. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. 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.

7. Signature of Employee	8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a
NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

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

A Recurrence of Disability is a work stoppage caused by:

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

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

INSTRUCTIONS FOR EMPLOYEE

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

INSTRUCTIONS FOR EMPLOYING AGENCY

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

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Notice of Recurrence

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

Employee: Complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0167
Expires: 07-31-08

Part A - Employee

1. Name of employee (Last, First, Middle)	2. Social Security Number	3. OWCP file number for original injury
Doe John D	111-11-1111	250000000

4. Date of birth Mo. Day Yr.	5. Sex	6. Home telephone
06/30/1954	☒ Male ☐ Female	(123)456-7891

7. Home mailing address (include city, state, and ZIP code)
679 Bean Street
Anywhere VA 22222

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

9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)
Defense Logistics Agency-HQ
8725 John J. Kingman Road VA 22222
Ft. Belvoir, VA 22060

10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
Same

11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work after recurrence (mo., day, year)	14. Date and Hour pay stopped after recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
01/30/2004 06:30 am	05/05/2004	05/06/2004 07:30 am		07/29/2004 07:00 am

☐ Medical Treatment Only
☒ Time Loss From Work

17. Date of first medical treatment following recurrence (mo., day, year)
05/05/2004

18. Name and address of treating physician
Dr. Henry Bombay
123 Hope Street VA 11111

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) ☐ Yes ☒ No

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
Radiating pain in neck and shoulder area

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
Constantly throbbing in neck/shoulder area. Because it is in the same area that I injured and I have sustained any new injuries in that area.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.
None

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the Federal Employees' Compensation Act (FECA), or who knowingly accepts compensation to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee	24. Date (mo., day, year)

Part B - Federal Employing Agency

25. 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 ZIP Code 22060

OWCP Agency Code

OSHA Site Code

26. Employee's duty station (street address and ZIP Code)

Defense Logistics Agency, HQ

8725 John J. Kingman Road

Ft. Belvoir VA ZIP Code 22060

27. Date of first return to FULL- TIME REGULAR duty following original injury

Mo. Day Yr. 07/29/2004

28. Regular work hours From: 07:00 ☒ a.m. ☐ p.m. To: 03:30 ☐ a.m. ☒ p.m.

29. Regular work days ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

30. Date of injury Mo. Day Yr. 01/30/2004

31. Date of recurrence Mo. Day Yr. 05/05/2004

32. Date stopped work after recurrence Mo. Day Yr. 05/06/2004 Time 07:00 ☒ a.m. ☐ p.m.

33. Date pay stopped after recurrence Mo. Day Yr.

34. Dates COP paid for recurrence From Mo. Day Yr. To

35. Date returned to work after recurrence Mo. Day Yr. 07/29/2004 Time 07:00 ☐ a.m. ☐ p.m.

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☒ No

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? ☐ Yes ☒ No

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? ☐ Yes ☒ No If so, provide full details.

None required.

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.

No

40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

A supervisor or compensation specialist 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.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)	42. Title	43. Work phone	44. Date (mo., day, year)
	Joe Boss	(703)111-1111	

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

   Not applicable

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

   None

4. What was your rate of pay if you stopped work due to this recurrence?

   $ 50,023.00 per year

5. Do you claim compensation for lost wages? ☒ Yes ☐ No

   If so, for what period? 05/06/2004 through 07/28/2004

6. Have you received any pay during the period claimed? ☐ Yes ☒ No

   If so, how much and from what source? _____

NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 to the U.S. Code. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. 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.

7. Signature of Employee	8. Date (mo., day, year)

• U.S. GPO: 2000-467-602/39549