DEPARTMENT OF THE NAVY
HUMAN RESOURCES SERVICE CENTER, SOUTHWEST
525 B STREET SUITE 600
SAN DIEGO, CA 92101-4418

Subj: STATEMENT OF UNDERSTANDING WORKERS' COMPENSATION

I certify I have read and understand the following information regarding my rights and responsibilities under the Federal Employees' Compensation Act (FECA):

1. I must immediately inform my supervisor if I sustain an on-the-job injury. I am required to advise the attending physician my employer has light/limited duty available and is willing to temporarily accommodate any physical restrictions I may have. I must immediately inform my supervisor, as soon as I am found to be able to return to work either light duty or full duty. If I refuse to work after receiving a valid written light duty job offer, I may lose my entitlement to compensation.

2. Temporary total disability (TD) means inability to perform any type of work for a certain period of time. I further understand I must notify my supervisor in the event circumstances occur that require my absence from home for extended periods of time. NOTE: (Reasonable absence from home are not vacations, pleasure trips, other employment paid or unpaid.)

3. Employees must be accessible by telephone on a daily basis in the event they must be contacted by the treating physician, supervisor, DOL, or Injury Compensation Office.

4. If I am found to be temporarily totally disabled or partially disabled and return to light or limited duty, I understand I am required to follow the doctor's orders and am prohibited from performing activities outside of the limitations specified by the doctor. Specifically, I am prohibited from or participation in work or recreational activities that might aggravate, prolong, or accelerate the injury or illness for which compensation and/or medical expenses are being paid. This restriction applies both on and off the job.

5. Employees are reminded that DOL needs a current street address and resident telephone number in order to facilitate prompt payment of compensation benefits, medical care, and correspondence from their office. Employees should notify, in writing, the Human Resources Office, _____ of any changes.

6. Employees are responsible for providing medical evidence of a disabling traumatic injury within 10 calendar days after submitting a claim for disability, CA-1 form. Failure to do so may result in my losing continuation of pay (COP) benefits.

7. In all reported cases of traumatic injury or occupational illness, it is my responsibility to submit, (or arrange for the submission of), a complete medical report from the attending physician. I understand I am required to telephone my supervisor the first work day after each medical appointment to keep my supervisor informed of my medical and duty status. I understand it is my responsibility to provide written documentation from my physician to my supervisor and request leave for my absence from work by completing a leave slip.

8. Continuation of Pay (COP), (45 days maximum), is payable only in cases of traumatic injury. Employees claiming occupational illness are not eligible for COP. COP may be paid only if the claim for traumatic injury (CA-1 form) is filed within 30 days from the date of injury. Unused COP days remaining after return to full/light duty may be used for recurrence of disability only if

the recurrence occurs within 45 calendar days after the first return to duty date, as long as lost time occurs within 45 days from date of injury.

9. I am required to promptly return to duty, including return in a partially disabled status when suitable work has been offered by my employer.

10. COP may be terminated if, upon evidence from the attending physician indicating that I am partially disabled, I refuse or fail to respond to a formal job offer of light duty employment offered by my employer.

11. COP may be denied if my injury was proximately caused by intoxication by alcohol or illegal drugs or if I refuse or obstruct a required examination.

12. If I refuse to participate in rehabilitation efforts, the DOL will, in the absence of evidence to the contrary, assume that rehabilitation would have resulted in return to work and will reduce compensation accordingly.

13. No payment or reimbursement for medical and/or travel expenses will be made if the bill is submitted more than 1 year beyond the calendar year in which the expense was incurred or the case was first accepted, whichever is later.

14. All earnings must be reported to DOL without regard to the level of compensation being received. I understand if I give a false or evasive statement, omit, conceal, or misrepresent facts relating to my claim, I may be subject to criminal prosecution. The maximum penalty for fraud is $10,000 and 5 years imprisonment, (or $10,000 and 10 years imprisonment for conspiracy to commit fraud).

15. Injury Compensation Specialists in the Human Resources Office, Code _____, can be reached at (619) _____, and are available to answer questions regarding the Federal Employees' Compensation Act (FECA) and/or to assist me in filing for Workers' Compensation benefits.

16. I understand that my failure to comply with the Federal Employees Compensation Act (FECA) may result in administrative discipline.

Printed Name: _____

Street Address: _____

_____

Residence Phone Number: _____

Signature: _____ Date: _____

THIS FORM MUST BE SIGNED & SUBMITTED WITH EACH WORKERS' COMPENSATION CLAIM FILED.