U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Worker's Compensation Programs

CLAIM FOR COMPENSATION ON ACCOUNT OF OCCUPATIONAL DISEASE

1. NAME *(Last, First, Middle)*
CHESTER, ROBERT L.

2. HOME MAILING ADDRESS ***(Number, Street, State, and Zip Code)***
19 Bock Street, S.E.
Washington, D.C. 20002

3. DATE YOU FIRST BECAME AWARE OF DISEASE OR ILLNESS ***(Mo., Day, Year)***
6/16/82

4. IF YOU LOST PAY, SHOW PERIOD COMPENSATION IS CLAIMED *(Mo., Day, Year)*
FROM: 5/16/82 TO: 5/25/82

5. SHOW AMOUNT OF ALL WAGES RECEIVED FROM ANY SOURCE DURING PERIOD SHOWN IN ITEM 4. ALSO GIVE EMPLOYER'S NAME AND ADDRESS IF OTHER THAN FEDERAL GOVERNMENT.
Used 56 hours of Sick Leave which I am applying for leave buy back.

6. WERE YOU EVER IN THE ARMED FORCES OF THE UNITED STATES? [] YES [] NO IF YES, FURNISH →	**A. SERVICE NUMBER** ----------	**B. NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED.** -------	**C. PERIOD OF SERVICE** FROM: THROUGH: - - - -

7. HAVE YOU EVER APPLIED FOR OR RECEIVED BENEFITS FROM THE VA BASED ON SERVICE IN THE ARMED FORCES OF THE UNITED STATES? [] YES [] NO F YES, FURNISH ----------→	**A. CLAIM NO.** ----------	**B. VA ADDRESS WHERE CLAIM IS FILED** ----------	**C. NATURE OF DISABILITY AND MONTHLY PAYMENT** $ ----------

8. HAVE YOU APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE U.S. CIVIL SERVICE OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW? [] YES [] NO IF YES, FURNISH ----------→	**A. CLAIM NO.**	**B. DATE ANNUITY BEGAN** ***(Mo., Day, year)***	**C. AMOUNT OF MONTHLY PAYMENT** $

9. DATE YOU FIRST REALIZED THE DISEASE WAS CAUSED OR AGGRAVATED BY YOUR EMPLOYMENT:
(Mo., Day, Year) **EXPLAIN WHY YOU CAME TO THIS REALIZATION.** 6/16/82
While temporarily assigned in Micronesia, explosive diarrhea and vomiting persisted for eight days. I have never experienced such a condition while in U.S.

10 LIST YOUR DEPENDENTS ***(If none, so state)***

NAME	RELATION-SHIP	DATE OF BIRTH	IS DEPENDENT LIVING WITH YOU? YES	NO	IF NOT, SHOW MAILING ADDRESS
Jane Chester	Wife	9/30/52			Same as above

11. SHOW AMOUNT PAID EACH MONTH FOR SUPPORT OF DEPENDENTS NOT LIVING WITH YOU
$ N/A
State whether payments were ordered by a court, and if so, attach a copy of the court order.

I certify that my disease or illness described above was a result of my employment with the United Sates 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 Employee's Compensation Act.

12. YOUR SIGNATURE OR SIGNATURE OF PERSON ACTING FOR YOU **DATE** ***(Mo., Day, Year)***

CA-4
(REV. AUG. 1976)

STATEMENT OF OFFICIAL SUPERIOR JAN 31, 1983

13. NAME AND MAILING ADDRESS OF REPORTING OFFICE *(Name, Number, Street, City, State, Zip Code)*
Peace Corps, Office of Medical Services,
806 Connecticut Avenue, N.W., Washington, D.C. 20526

14. DATE & HOUR PAY STOPPED *(Mo., Day, Year)* 5/16/82 [] AM [] PM

15. PAY RATE AT TIME EMPLOYEE STOPPED WORK.

	BASE PAY	SUBSISTENCE	QUARTERS
AMOUNT $ $18,712 PER yr.	$ PER	$ PER	$ PER
	$ PER	$ PER	$ PER
	$ PER	$ PER	$ PER

16. IF EMPLOYEE RECEIVES OTHER ADDITIONAL PAY, SUCH AS PREMIUM, SUNDAY, OR NIGHT DIFFERENTIAL IDENTIFY TYPE AND SHOW AMOUNT.
TYPE $ N/A PER

17. SHOW WORKWEEK AT TIME PAY STOPPED IF OTHER THAN MONDAY THROUGH FRIDAY
S M T W T F S

18. SHOW INCLUSIVE DATES EMPLOYEE RECEIVED PAY FOR ANY PART OF THE PERIOD SHOWN IN 4 ON THE FRONT OF THIS FORM

ANNUAL LEAVE:	SICK LEAVE:	OTHER
FROM TO	FROM 5/16/82 TO 5/25/82	FROM TO

19. DID THE EMPLOYEE WORK IN THE POSITION A FULL ELEVEN MONTHS PRIOR TO STOPPING WORK DUE TO THE ILLNESS OR DISEASE?
[] YES [] NO

20. IF ANSWER TO 19 IS NO, WOULD THE POSITION HAVE AFFORDED EMPLOYMENT FOR ELEVEN MONTHS EXCEPT FOR THE DISEASE OR ILLNESS?
[] YES [] NO

21. DEDUCTIONS

	HEALTH BENEFITS	OPTIONAL LIFE INSURANCE
A. WAS EMPLOYEE ENROLLED ON DATE PAY STOPPED?	[] YES NO []	[] YES NO []
B. IF YES, FURNISH CODE NUMBER	[][][]	[][][]
C. IF YES, GIVE MONTH, DAY, YEAR, THROUGH WHICH DEDUCTIONS WERE MADE.	( )	( )

22. (CHECK ONE)
[] EMPLOYEE HAS NOT RETURNED TO WORK
[] EMPLOYEE HAS RETURNED TO WORK *(If this box is checked complete items 23 through 26)*

23. DATE AND HOUR RETURNED TO WORK *(Mo., Day, Year)*
8:30 [] AM [] PM
5/16/82

24. SHOW EMPLOYEE'S WORKWEEKON RETURN TO DUTY IF OTHER THAN MONDAY THROUGH FRIDAY
S M T W T F S

25. SHOW EMPLOYEE'S RATE OF PAY ON RETURN TO DUTY

BASE PAY	SUBSISTENCE	QUARTERS	BASE PAY
$ 18, 712 PER yr.	$ PER	$ PER	$ PER

26. DID THE RESULTS OF THE DISABILITY REQUIRE A CHANGE IN THE EMPLOYEE'S WORK ASSIGNMENT ON RETURN TO DUTY?
[] YES [] NO *(if yes, complete A)* ----------→

A. DESCRIBE TYPE OF WORK EMPLOYEE IS NOW PERFORMING

27. I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE AND FURNISHED BY THE EMPLOYEE ON THE REVERSE OF THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE WITH THE FOLLOWING EXCEPTIONS:

28. SIGNATURE OF OFFICIAL SUPERIOR	29. TITLE	30 DATE *(Mo., Day, Year)*
John Williams	Director, NANEAP Region	July 6, 1982

CA-4
(REV. AUG. 1976)

INSTRUCTIONS FOR COMPLETING CLAIM FOR COMPENSATION ON ACCOUNT OF OCCUPATIONAL DISEASE CA-4

This form should be completed by the injured employee and the official superior in all cases when an employee:

1. Is disabled and in a non-pay status for more than three calendar days,

2. Suffers a scheduled permanent impairment, or

3. Is unable to resume his / her usual work.

Claim for loss of pay should be filed 10 calendar days after the employee enters a non-pay status or upon return to work, whichever occurs first. Claim for schedule award based on a permanent impairment should be submitted when the extent of impairment is known.

Compensation cannot be paid without medical evidence to support the claim, therefore, it is very important that the attached medical report, form CA-20, be separated and Forwarded to the attending physician when form CA-4 is completed.

Items 1 through 12 should be completed by the injured employee or someone acting on his behalf. Items 13 through 31 should be completed by the employee's official superior (complete items 24 through 27 only if employee has returned to work). The form should then be forwarded to the office of the OWCP servicing the employing establishment.

Employees are advised that fraudulent claims are punishable by a fine of not more than S2,000 or by imprisonment for not more than one year or both.

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

The official superior should complete items 1 through 4 on the front of form CA-20 prior to forwarding the form to the attending physician. These items are the same as items 1-4 on the front of form CA-4. It will also be necessary to show on the back of the form CA-20 the address of the OWCP office to which the form should be sent.