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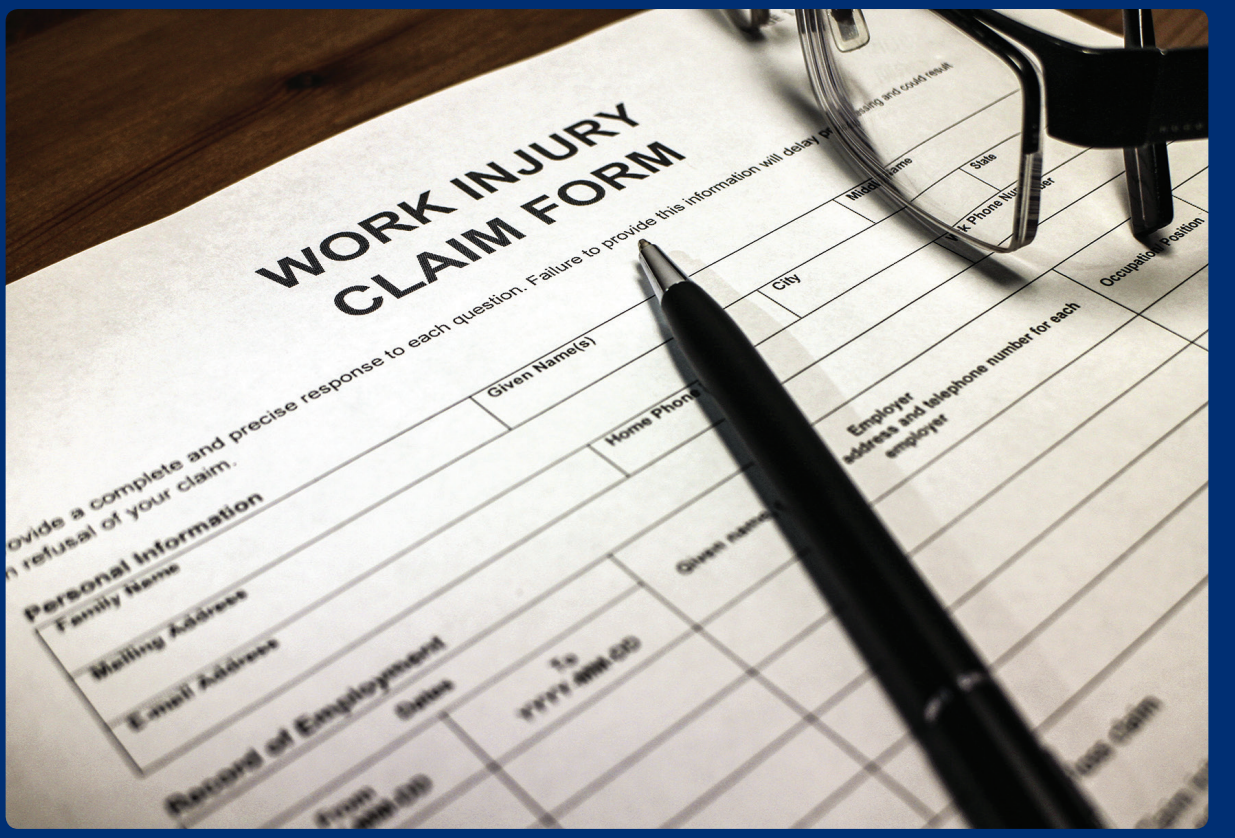







Workers' Compensation Manual

2014 Edition

AFGE Field Services and Education Department

Prepared by AFGE Field Services & Education Department
and AFGE Member Services Department, October 2014

Table of Contents

The information contained in this manual was gathered, produced, and published in good faith however, the general priciples set forth in this manual depend upon the specifics of the fact situation involved. Similarly, laws, rules, and regulations change over time and this manual may be outdated or certain propositions no longer valid because of changes or interpretations. Neither this manual nor its contents should be construed as legal advice or a substitute for legal advice for a particular case or situation.

INTRODUCTION

Agencies that employ our members often react to the high cost of workers' compensation by focusing on reducing outlay. Be assured that AFGE fights against such cuts so your health and safety on the job is protected. We encourage agencies to work with us to prevent injuries and illnesses so that our valued AFGE members go home to their families intact. But it's not a perfect world.

Employees who are injured or get sick as a result of work are entitled to compensation. The process can be confusing and lengthy. And it can be especially frustrating when the agency involved does not follow through on its employer obligations.

Employees sometimes come to the local union for help with workers' compensation claims. Usually, they're having problems with claim procedures or questioning a denied claim. AFGE wants to help local union leaders and activists, understand the process to better assist their members. AFGE also maintains a wealth of resources on specific issues.

This manual is a concise explanation of what to do when a member, injured or ill as a result of work, comes to the local union for help. It is meant to help you understand the system and employees' rights and responsibilities.

We explain how to file a claim, benefits the employee may be entitled to receive, the difference between traumatic injuries and occupational illnesses or diseases, claims for recurrences, returning to work, and appeal rights for denied claims. We also offer advice based on experience.

There is also a chapter on useful resources. For example, the Office of Workers' Compensation Programs (OWCP) has published more detailed information than is covered here but we provide you with online links, addresses and phone numbers to that information. And there's a chapter on using the workers' compensation process as an organizing and mobilizing tool to grow your union membership.

Most claims are resolved promptly and without problems, but workers' compensation can be a complicated system. To avoid delays in processing, employees need to be thorough when filing forms with OWCP. It is imperative that their physician state there is a causal relationship between the condition being claimed and the work the employee performs, their physical limitations and the possibility of their returning to work. As the local leader and activist working on workers' compensation, it is your responsibility to be sure members who file claims are complying with OWCP requirements and that the agency is complying with their obligations. Your National Office and your District Office are ready to help.

CHAPTER 1

BASIC REQUIREMENTS
WHAT IS WORKERS' COMPENSATION?

The Federal Employees' Compensation Act (FECA) was passed in 1916. It provides federal employees with workers' compensation benefits in the event they are injured or become ill as a result of doing their jobs. FECA is the exclusive remedy for on-the-job injuries or illnesses. That means the employee cannot sue the federal government for the injury or illness. The compensation program was set up to be non-adversarial; however, most employees who have filed claims feel the system can be hostile and frustrating.

The Federal Employees' Compensation Act is administered by the U.S. Department of Labor. Specifically, the Office of Workers' Compensation Programs (OWCP) is charged with processing claims. Most federal employees are familiar with OWCP and often refer to issues related with the workers' compensation process as "OWCP."

The OWCP District Offices responsible for making decisions on injury or illness compensation claims are listed in Chapter 8 – Resources.

A. TIMELY FILING

As a general rule, three years is the time limit for initially filing an OWCP claim. It is to the employee's advantage to file a claim immediately after becoming aware of a medical condition that was caused by work.

OUR ADVICE

Claims should be filed as soon as possible. OWCP might question claims filed after a lag time because they might doubt the seriousness of the injury. This does not mean the claim will be denied, but the claimant should have a good reason for not filing earlier. Also, the medical documentation will be even more important if the claim is not filed as soon as possible.

The three-year deadline begins from:

- Date of Injury – when the employee was hurt
- Date of First Awareness – when the employee became aware that the condition was related to the job
- Date of Last Exposure – mostly in cases of chemical exposure

There are other deadlines associated with receiving certain benefits which will be covered in detail later. For example, in order to be eligible for Continuation of Pay (COP), the claim must be filed within 30 days of the injury.

B. CIVIL EMPLOYMENT

This means the employee must be a civilian employee of an agency covered by FECA. Most AFGE members are civilian employees and would meet this requirement. One group

of members that is not covered by FECA is the Non-Appropriated Funds (NAF) workforce. They are covered by the Longshore and Harbor Workers' Compensation Act (33 USC 941), which is not addressed in this manual.

C. FACTS OF INJURY OR ILLNESS

Establishing a clear factual basis for an OWCP claim is essential. It could mean the difference between a successful and unsuccessful claim. The most important facts include:

1) the details of the injury, illness, or disease; 2) relevant medical facts concerning the condition of the employee; 3) the connection between the occurrence of the injury, illness, or disease and the employee's performance of his or her duties; and 4) a causal relationship between the employee's medical condition and the injury, illness, or disease. Each of these items is discussed in detail below.

1. Factual

The factual information relating to the incident can include the time and place of the incident, what the employee was doing, who may have witnessed the incident, or anything else about the circumstances surrounding the event. It is important to document the events as they happened and to identify body parts affected by the incident.

OUR ADVICE

The description should include not only body parts immediately hurt or affected, but any body parts involved in the incident. Other body parts could potentially be affected but if they are not included in the original write-up, OWCP might question any claims for benefits based on body parts or health effects not mentioned in the original claim.

2. Medical Facts

The medical facts of the injury include supporting medical evidence of the condition being claimed, any symptoms the employee reports to the physician, subsequent treatment and expected recovery time.

This is a crucial component of the workers' compensation claim. Without it, the claimant will receive notice that more information is needed. If the medical evidence does not support the claim, it likely will be denied. It is best to report this information as completely as possible early in the claims process.

D. PERFORMANCE OF DUTY

Employees must show they were working as a federal employee. Essentially, employees must show they were carrying out their duties and describe those duties at the time of the incident.

In addition to the times when employees are carrying out their work duties, they are considered to be in the performance of duty:

- While on the premises of the employing agency
- At reasonable times before and after work
- If performing representational duties that allow use of official time
- In parking facilities owned, controlled or managed by the agency
- In agency housing, such as firefighters
- Off the premises, if performing a job function, such as letter carriers.

Employees are not covered going to and from work, except where the agency provides transportation or the employee is expected to use his or her own car for work. Employees are not covered during their lunch hour, unless performing a work-related activity.

Employees are covered 24 hours for reasonable incidents while on travel orders. For example, a fall in the hotel would be covered, but a fall while out sightseeing would not qualify.

There are other factors that would be considered on a case by case basis:

- **Recreation:** If an employee is injured during an employer-sponsored activity.
- **Horseplay:** If employees are in a personal association for long periods of time.
- **Assault:** If it arises out of a work function. If it is of a personal nature but aggravated by work situations, it may be covered.
- **Emergencies:** If an employee is providing emergency help, such as helping put out a fire.

E. CAUSAL RELATIONSHIP

Causal relationship refers to the link between the incident or work-related exposure and the medical condition being claimed. There are four types of causal relationships covered by FECA.

1. **Direct Causation** refers to the clear link between the incident and the medical condition. One example is a fall and the resulting broken leg.

2. **Aggravation** refers to the incident at work making an existing condition worse. One example is a bad knee due to military service that is made worse by a job that requires frequent bending at the knees.

3. **Acceleration** refers to speeding up a reaction or existing condition. For example, an employee with diabetes may develop worsening health effects because the employee's work does not allow regular times for the employee to eat or to monitor the condition.

4. **Precipitation** refers to the work exposure or incident bringing about a condition or reaction sooner than it would have come about without the exposure. For example, an employee who was infected with tuberculosis (TB) develops active TB after being exposed to a patient with active TB.

F. STATUTORY EXCLUSIONS

Claims that can be shown to be caused by willful misconduct, drug or alcohol intoxication, or intent to injure self or others will not be accepted by OWCP.

CHAPTER 2

BENEFITS

Workers' compensation benefits are there to ensure that the worker hurt or made ill on the job recovers and gets back to work. It provides for medical expenses, wage-loss compensation, and vocational rehabilitation, if needed, among other benefits.

A. MEDICAL CARE is provided and the claimants may initially select a local physician of their choice. The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists and chiropractors within the scope of their practice as defined by state law. Payment for chiropractic services is limited to treatment consisting of manual manipulation of the spine to correct a subluxation, as demonstrated by X-ray to exist. A subluxation is a deviation of one or more bones in the spine (vertebrae) that puts pressure on or irritates the nerves near them.

Mileage to and from medical treatment is a reimbursable expense (usually within 25 miles of the claimant's home or workplace, or if there is no appropriate care within that distance).

Some agencies contract with medical providers to examine their injured employees. Others, such as the Department of Veterans Affairs, have medical providers on the premises. In both cases, agencies encourage workers to see these providers. Employees should not be pressured to see the agency physician. They are still free to choose their own physician.

OUR ADVICE

Employees should get the immediate medical attention they need at the nearest medical facility. However, we recommend that they then choose their own physician. While providers associated with the employer may provide adequate care, employees should remember they are being paid by the employer. Make sure employees know that if they see the same provider ***twice*** after the initial visit, that provider will be considered their physician of record as far as OWCP is concerned. If they later want to change physicians, they will have to make a written request to OWCP explaining their reasons.

CONTINUATION OF PAY (COP) is applicable for traumatic injuries for up to 45 calendar days of medically supported disability. It is paid by your agency and should reflect the amount of your regular check. Forty-five days is the timeframe OWCP sets for adjudicating and resolving most injury claims.

Some agencies encourage workers to use leave, annual or sick time instead of requesting COP, in the event the claim is not accepted.

OUR ADVICE

For most employees, choosing COP is the better option, assuming they have a valid claim. Agencies often advise employees to use annual or sick leave in case their claim is not accepted. However, employees are entitled to use this benefit and should not be charging their own leave for absences caused by a workplace injury. If a claim is in fact denied, the agency can then charge the employee sick or annual leave for any portion of the COP taken.

B. WAGE-LOSS COMPENSATION is a benefit to replace an employee's lost wages when he or she cannot work because of a workplace injury or illness.

1. **Total Disability** wage loss is paid when a worker has no capacity to earn wages, due to a workplace injury. It is paid at the rate of two-thirds (2/3) of the employee's earnings at the time of injury, or three-fourths (3/4) if there are one or more dependents. It includes pay premiums such as night differentials and hazard duty pay, and is tax free. It does not include overtime pay.

2. **Partial Disability** wage loss is paid at a reduced rate when the worker is able to perform some work and only has a partial loss of wage earning capacity.

3. **Cost of Living Allowances (COLAs)** are provided annually to injured workers who received wage loss compensation in the preceding year.

C. VOCATIONAL REHABILITATION is available when a claimant has recovered medically as much as possible but can no longer perform the duties of the job. OWCP will facilitate a meeting with a vocational counselor who will help the injured employee identify other types of work he or she can do and recommend to OWCP any training the employee might need. OWCP will pay for the time the employee is in training and help with job placement.

Usually, the first effort is to place the employee at the same agency or with another federal agency in order to keep the employee in federal employment. Sometimes, it's necessary to explore the private sector. OWCP does not guarantee alternate employment. This is only a benefit available to injured employees who may not be able to remain with their employing agencies because they can't do their jobs. Some agencies choose not to participate.

D. SCHEDULE AWARDS are paid if there is a permanent impairment of the injured part or function of the body, such as loss of vision, an arm, or removal of a lung. The law prohibits payment of schedule awards for back, neck, or brain injuries, unless such an injury physically impairs another element of the body. Claims for a schedule award are filed on a Form CA-7. You cannot receive a schedule award and total wage loss compensation for the same injury at the same time. Schedule awards should be requested when the individual has reached Maximum Medical Improvement (MMI), as determined by their physician. A schedule award can also be paid for serious disfigurement of the head, face or neck, which is likely to make it harder for the claimant to get or keep another job.

E. ATTENDANT ALLOWANCE can be paid when the injured employee has a disability that requires someone to provide personal care services.

F. DEATH/BURIAL benefits are paid to the survivors if the death was a direct result of the work environment, or previous work injury. Form CA-5, or 5b, is the appropriate form to file.

CHAPTER 3

HOW TO FILE A CLAIM

The agency must provide the Compensation Act (CA) forms that the employee needs. Each form includes instructions for the completion and submission of all information and evidence to process the claim. To avoid delays, it is vitally important that the employee provide all information the first time it is requested by OWCP. Be certain to obtain the right forms. There are different forms to file if an employee is injured or made ill as a result of the employee's job. Other forms request information from the employee's doctor about the employee's ability to work as well as the progress the employee is making. There are also forms to request compensation during the time the employee cannot work due to injury or illness.

Once the employee submits the claim, the agency submits it to the OWCP District Office that services the agency's location. When OWCP receives the claim, it sends the employee a pamphlet about rights and benefits under FECA and a claim number.

ECOMP - The Employees' Compensation Operations & Management Portal is a web-based system for electronic filing of key claim forms. It makes it easier to submit and track documents.

OWCP, not the employing agency, decides if a worker has a compensable injury and what benefits he is entitled to under FECA. When the claim is approved by OWCP, it will notify the employee in writing of its acceptance of a specific medical condition. OWCP may also send a request for additional information to make a decision about the claim. Make sure the employee meets the deadlines for submitting information. If the deadline has passed, OWCP will make a decision based on the information in the file.

OUR ADVICE

Agencies sometimes delay the submission to OWCP for various reasons. Sometimes the workers' compensation staff is on leave, files are inadvertently misplaced, or the agency is waiting for more information from the employee. According to OWCP, agencies should not be holding back paperwork-- even if they believe the claimed injury or illness is not work-related. All paperwork submitted by the employee should be forwarded to OWCP. To prevent these delays, especially when there is a known history of delays, employees should be encouraged to send copies of everything they submit to the agency directly to OWCP. Using ECOMP will prevent delays in agency handling.

Some agencies require employees to file electronically at the agency. At the VA, for example, employees are required to use the ASISTS program--the Automated Safety

Incident Surveillance Tracking System. Before a claim can be initiated, the employees are required to notify their supervisors, who then enter information on ASISTS and give employees a number. The employee then enters the information required, and a CA-1 or CA-2 is generated. Other record-keeping forms are generated at the same time. Other agencies have similar programs and reporting requirements. Make sure you know what they are, and make sure employees know. They may have been told how to report during their new employee orientations or they may have forgotten.

A. TRAUMATIC INJURIES

A traumatic injury is a wound or other condition of the body that is caused by external force, including stress or strain, identifiable in time and place, and that is the result of an incident, or a series of incidents, that occur during a single workday.

Claims for traumatic injuries are filed on a ***CA-1: Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.*** After being injured, the employee, or someone acting on his behalf, should report the incident to the supervisor. The injured employee should get medical attention as soon as possible. In addition to the CA-1, many agencies have their own incident reporting forms for purposes of tracking injuries and illness for health and safety records. The employee should fulfill the reporting requirements of the agency.

The employer or anyone acting on the employer's behalf (such as the supervisor, HR or workers' compensation specialist), cannot refuse to accept the employee's notice of injury or illness or keep it without sending it to OWCP.

The CA-1 has two parts: One for the employee to complete on the front; and another for the supervisor or human resources staff to complete on the back. The employee portion includes a description of the events surrounding the incident, how the employee was injured, and which body parts were affected. We have provided some sample descriptions at the end of this chapter.

Workers' compensation forms are typically handled by the HR staff after the supervisor fills in the necessary sections. The CA-1 must be transmitted by HR to OWCP within 10 workdays from date the agency receives the form.

OUR ADVICE

The employee and the employee's representative should always keep copies of the forms and any other documents accompanying the CA-1. The local union should get a copy of anything that the employee submits to the agency or OWCP if the local is serving as the employee's representative.

Continuation of Pay

Traumatic injuries are eligible for continuation of pay (COP). Employees should elect COP unless there is some unusual reason for them to use their own leave. COP is regular pay from the agency and may be continued up to 45 ***calendar*** days. COP is paid only for

traumatic injuries, not for occupational illnesses or diseases.

To be eligible for COP, the Form CA-1 must be filed within 30 days of the employee's traumatic injury. If the employee has chosen COP on the Form CA-1 and provided the required medical documentation within 10 days, the agency must pay COP. If COP is denied because the claim was not filed within 30 days, the employee may still claim compensation for wage loss from OWCP on Form CA-7, Claim for Compensation, which will be discussed later.

It is the employee's responsibility to provide the agency (within 10 working days after claiming COP) medical evidence that states that the employee is totally disabled as a direct result of the workplace injury. If the employee does not do this, the agency may stop COP until they receive the medical evidence.

Also, to receive COP, disability has to begin within 45 days of the injury. Claims that are first filed after the employee is terminated are not entitled to COP.

If an employee has already used paid leave for a work-related injury or illness, the employee can have it converted to COP for up to one year after the date of the injury, once the claim is accepted by DOL.

If the employee is working, any time taken for medical appointments is counted as a full day of COP during the 45-day period. For example, an employee who has returned to work full-time has a follow-up appointment and requests two hours during the work shift. That counts as one day of COP.

CA-16: Authorization for Examination/ Treatment

The supervisor or workers' compensation specialist in the HR or personnel office should give the employee a ***Form CA-16: Authorization for Examination/Treatment.*** This form authorizes the initial exam and treatment and guarantees payment of all non-invasive procedures and routine treatment or examination for 60 days after a traumatic injury. The supervisor completes the front of the form, and after examination, the physician completes the back. The employee submits the form to the employer, who then forwards it to OWCP with the claim form.

The CA-16 is primarily used to authorize treatment in an emergency basis. OWCP requires that it be issued to the employee within four hours of the injury. Verbal authorization for medical examination/ treatment can be given, especially in emergency situations, but a CA-16 should be issued within 48 hours of the verbal authorization. The agency is not required to give a CA-16 if it has been more than one week after the incident. However, with prior approval from OWCP it can be issued even if it is later than one week.

The CA-16 does not authorize exercise equipment, surgery, work hardening (a physical conditioning program), etc. If these are required for medical treatment, the employee or the employee's doctor should request approval from OWCP once the claim is accepted.

The requirement for the agency to issue a Form CA-16 is clearly stated in 20 CFR Part 10 §10.300 (b): "The employer shall issue Form CA-16 within four hours of the claimed injury." In spite of this requirement, some agencies try to deny workers their right to medical attention.

OUR ADVICE

Take immediate action if you learn the agency is denying or delaying the CA-16. Keep copies of the CA-16 to counter claims that they are not available. Remind management of their obligation to issue the

CA-16. If they do not comply, file a grievance and file a compliant with the OWCP District Office with jurisdiction over your agency.

Employees are entitled to the initial selection of a physician of their own choosing for treatment of an injury. Agency management may not interfere with an employee's right to choose a treating physician or require the employee to go to the agency's physician before seeing the employee's own.

Employees can be reimbursed for travel costs if the physician is located within 25 miles of their home or workplace, or if there is no appropriate medical care within that range. Employees may choose medical care beyond that distance, but OWCP will not cover it. Claims for reimbursement are made on Form OWCP-1500a or on a standard billing form such as the HCFA 1500. These forms should be provided with the CA-16 if the employee is seeing a private physician. To claim travel expenses, submit Standard Form 1012 along with receipts.

Agency management may not contact the employee's physician by telephone. They may contact the physician only in writing and only to obtain additional information or clarification about the employee's duty status or medical progress. The employer must give the employee and OWCP a copy of any written communication between the agency and the employee's physician. Faxes and e-mails are considered written communications.

Another form employees will need is ***Form CA-17, Duty Status Report.*** On this form, the employee's doctor will fill out information about the employee's ability to work, how long the employee may need to stay away from work and whether the employee can continue to work with some restrictions.

CA-7, Claim for Compensation

If the treating physician believes the employee's disability (either total or partial) is going to continue beyond the 45 calendar days of COP, the employee should request ***Form CA-7, Claim for Compensation.*** Employees should request the CA-7 on the 30th day, if not provided by the agency, so that they do not have to go without pay. The completed CA-7 should be submitted to the agency at least five working days before the end of the 45 days of COP, that is, on the 40th day.

Attached to Form CA-7 is ***Form CA-20, Attending Physician Report***, which must be completed by the employee's physician.

Wage loss compensation can be for either short-term disability or for long-term or permanent disability.

B. OCCUPATIONAL DISEASES OR ILLNESSES

An occupational disease or illness is a medical condition produced by continued and repeated exposure to conditions at work, including stress or strain, which occurs over a longer period of time than a single work-shift. Examples include repetitive motion disorders, asbestosis and occupational asthma.

The employee or someone acting on the employee's behalf should notify the employee's supervisor, using ***Form CA-2, Notice of Occupational Disease and Claim for Compensation***, within 30 calendar days from the date on which the employee was first aware of a possible connection between the illness or disease and the employee's job. If it is impractical for Form CA-2 to be provided to the supervisor, written notice should be given to any agency official or the employee can notify OWCP directly.

It is important for employees to follow all of the instructions on Form CA-2. Employees have to make sure to provide a narrative statement explaining the cause of the condition and the attending physician's name and address.

Form CA-2 has two parts: The employee completes the front and the supervisor or HR completes the back. It must be transmitted by the employer to OWCP within 10 workdays. Typically, this is the responsibility of the human resources staff.

COP is not authorized for an occupational disease or illness claim. Also, ***Form CA-16, Authorization for Examination and/or Treatment*** is not automatically provided for occupational claims. Authorization for treatment will be issued by your agency only with the approval of OWCP. The agency can call OWCP to get approval to issue a CA-16 if necessary. In most illness or disease cases, there is no need for emergency medical treatment. The employee will see a physician and obtain the medical information necessary to support the claim for compensation. Once a claim is approved, medical expenses related to the accepted illness or disease will be reimbursed. The employee should keep all receipts and statements related to the claim in order to submit them for reimbursement. Form OWCP-1500a or a standard billing form such as the HCFA 1500 is used to request reimbursement. Mileage reimbursement is requested on Standard Form 1012.

When filing a CA-2, employees will also need to file a ***Form CA-35, Evidence Required in Support of a Claim for Occupational Disease***. It is a checklist, and there are specific forms for seven different conditions and occupational diseases that are designated **A-H**. For example, the CA-35B is for work-related hearing loss, the CA-35C is for asbestos-related diseases, and the CA-35H is for carpal tunnel syndrome. The forms list information required from both the employee and the supervisor, and lists the requirements for medical information.

C. RECURRENCES OF INJURY OR ILLNESS/ DISEASE

A recurrence is defined by OWCP as a work stoppage or a need for further medical treatment after an employee has returned to work after being out due to an accepted medical condition that resulted from work. It is possible that OWCP will combine or "double" the new claim with the previously accepted claim. If so, OWCP will notify the claimant and the employee would continue to use the old claim number.

Filing claim for recurrence

Recurrences are claimed by filing a ***Form CA-2a, Notice of Recurrence***. A recurrence can be a spontaneous return of symptoms of the original injury, illness or disease without an intervening incident. It can also be a disability due to some consequence of the original injury, illness or disease. For example, a fall due to a weakness in the knee caused by an accepted injury. A claimant can also file a notice of recurrence if a light duty assignment is withdrawn for reasons other than non-performance.

If the return of symptoms is not spontaneous but is caused by an event or a series of events at work that occurred on a single work shift, it is considered a **new** traumatic injury by OWCP and a new Form CA-1 would have to be filed. The employee would also be entitled to a full 45 days of COP.

If the return of symptoms is caused by a series of events that occurred on more than one work-shift, then it would be considered a **new** occupational illness and a new CA-2 would have to be filed.

D. CLOSED CLAIMS

Once a claim is accepted, but no OWCP benefits are claimed or paid during a six-month period, then the claim may be administratively closed by OWCP. This does not mean that the claim has been denied or that the employee is not entitled to further benefits. If the employee's claim has been

closed due to inactivity, then Form CA-2a would be used to reopen the claim. The employee must note on the form that he or she is filing the CA-2a for medical benefits so a medical bill, prescription drug bill or whatever OWCP benefit the employee is seeking can be paid.

Even if OWCP closed the claim, that should not impact the employee's limited duty or rehabilitation job.

A list of the most common forms and their use has been included in Appendix B.

Sample Incident Descriptions

It is important to fill out the description in the claim form with as much detail as possible. Do not be limited by the space on the claim form. If the employee needs more space, an additional sheet of paper can be attached. Employees should include information about their duties, what they were doing, all body parts that were affected (even if not all were hurt in the incident) and what symptoms they felt at the time or after the incident.

Here are some description examples of events resulting in injuries.

Susan, a Claims Representative, fell at the workplace.

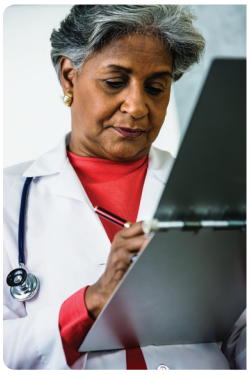
On November 15 at about 1:30 p.m., I was walking in the corridor outside Room 703 on my way to a meeting in Room 752 to discuss proposed changes in tracking claims. I slipped on the floor and fell on my back. My back, right hip, right hand, and right shoulder hit the floor. I cried out in pain. John Smith was with me. He helped me to my feet and I continued walking to the meeting. I was walking very gingerly and felt pain in my back, my right hip, my right hand, my right shoulder and my neck. I also had a headache. I left the meeting at about 1:45 p.m. due to the pain I was feeling. I contacted my supervisor and said I wanted to leave to go see my doctor.

Joe, a Material Handler, had a heavy box fall on his foot.

On June 13 at about 10:15 in the morning, along with my coworkers Jose Rivera and Peter Rollins, I was on the loading dock unloading boxes containing modular office furniture that had just arrived from a supplier. This type of work is part of my assigned duties. I was lifting a box that weighed approximately 40 pounds to put it on a hand truck, it slipped and fell on my left foot. As it fell, it hit my left shin and left ankle. I was wearing my safety shoes at the time; however those shoes do not protect the lower leg and ankle. I tried to "walk it off" but the pain was too severe. I went immediately with Peter to our supervisor to report this accident. I had great difficulty putting any weight on my left leg.

Donna, a Nurse's Aide, was hurt while lifting a patient out of bed.

On Tuesday, March 11, I was assigned to work in D Ward. At about 2:00 p.m., I was helping patient Robert Miller get out of bed and transferring him to a wheelchair so that he could be brought to physical therapy. When I straightened up while he was still in the bed, I felt a sharp pain on the right side of my back, in my right shoulder, and in my neck. I used the call button to get another staffer to assist me. An R.N. came to help me get Mr. Miller into the wheelchair. I wheeled him to physical therapy and then went to my supervisor to report the accident. My back, right shoulder, and neck still hurt, and the fingers in my right hand were tingling. I left work at about 2:45 p.m. I called my doctor but could not get in to see him until Wednesday morning.



CHAPTER 4

MEDICAL REPORTS

Medical reports are probably the most important element of a workers' compensation claim. They are also the main reason claims are denied. This is an area where help from the local union is most important. Helping employees understand what is required will, in turn, help them explain to their physicians what is needed for OWCP to find medical reports acceptable and approve their claims.

According to OWCP, the medical report should include:

- **Dates of examination and treatment**
- **History as given by the claimant**
- **Findings**
- **Results of x-rays and laboratory tests**
- **Course of treatment**
- **Other conditions found but not due to the claimed injury**
- **Diagnosis**
- **Treatment given or recommended for the claimed injury**
- **Prognosis for recovery**
- **All other material findings**

The physician must also state, the causal relationship between the condition and injury sustained. This applies to the initial claim and to claims of recurrence. In the case of a recurrence, the doctor must state how the current condition is related to the original injury. If other physicians treated the claimant after he or she returned to work following the original injury, the claimant must obtain similar medical reports from each treating physician.

Finally, the physician should describe the employee's ability to perform his or her regular duties. If the employee is disabled and cannot perform his or her regular duties, the physician should identify the dates of disability. If the employee is able to do only parts of his or her regular job, the physician's report should also include any work restrictions. Most agencies require that employees tell their physicians that light duty work is available.

The most common problem with medical reports is that it does not address the information OWCP is expecting. The medical report may be too vague or it may not provide enough detail. It is most important that the medical report address the issue of causal relationship, that is, whether the incident at work caused the medical condition for which compensation is being claimed and how. In this area, the medical report must be as decisive as possible. Words such as "may," "could," or "might be" can raise questions about the direct relationship of the claimed injury to the workplace.

The medical report should also be as accurate and complete as possible. It is helpful for the doctor to refer to the employee's statements about his or her work. Medical reports should be updated at least every six months to support the medical services the claimant is receiving.

Second Opinions and Referee Opinions

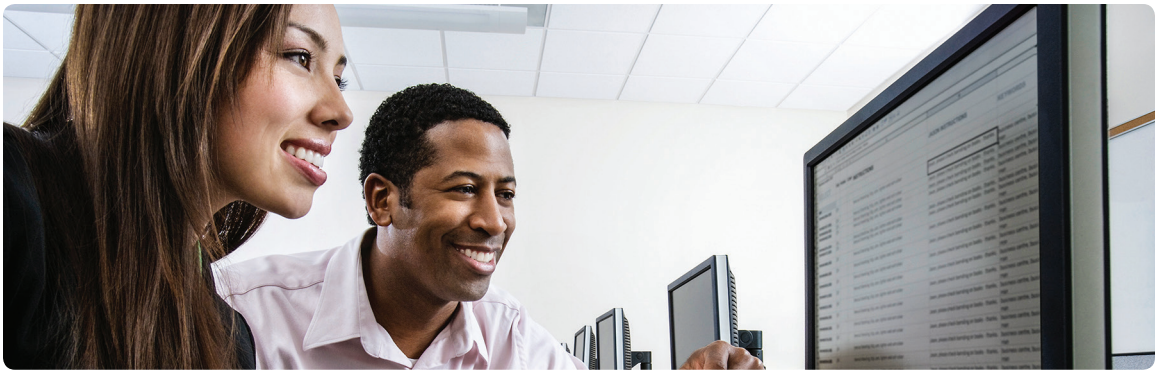
Even when the claim is originally accepted, there are some reasons for OWCP to send a claimant to a second opinion examination. It may be that the claimant is taking longer to return to work than OWCP believes the original injury or illness warrants. It may be that the attending physician is requesting treatments or diagnostic exams beyond what OWCP usually grants for that injury or illness. OWCP may also send claimants who submit reports from a general practitioner to a specialist for a second opinion.

If OWCP sends the claimant for a second opinion, it will usually notify the claimant and make the appointment. The claimant is obligated to go to the appointment unless there are reasons why he or she cannot. The claimant should then explain those reasons to OWCP and discuss other arrangements. OWCP can stop compensation payments until the claimant goes to the second opinion exam.

If there is a conflict between two medical opinions, such as the attending physician and the second opinion doctor, OWCP may refer the claimant to a third doctor. The third doctor is called the referee doctor and the opinion of the referee doctor decides the conflict between the other two and OWCP treats that opinion as the final say.

OUR ADVICE

If the referee doctor's opinion is contrary to your attending physician, the only way to rebut that opinion is by seeking another examination from a doctor of the same specialty and training as the referee doctor.
OWCP will have no choice but to consider the latest opinion. This will have to be at the expense of the claimant, as OWCP will not pay for examinations beyond the referee doctor.



CHAPTER 5

RETURNING TO WORK

The Federal Employees Compensation Act (FECA) requires injured employees to inform their treating physicians that the agency may be able to provide them with work that accommodates any medical limitations imposed by their injury or illness. If a work-related medical limitation is temporary, then the employee would be placed in a limited duty job. If the employee's condition is permanent, the agency may place the employee in a medically suitable rehabilitation or re-employment position.

Some agencies may try to remove from federal employment an employee who can no longer perform their duties. Others encourage employees to take a disability retirement.

OUR ADVICE

The local union should fight all agency efforts to fire employees who have been hurt on the job. If the person is permanently disabled and his or her claim has been accepted by OWCP, he or she is entitled to workers' compensation benefits.

A. LIGHT DUTY

There are several different but synonymous terms used to describe positions that take into account medical restrictions, including light duty, limited duty, restricted duty and modified duty. OWCP typically refers to "light duty" positions and most agencies use these terms interchangeably. However, TSA uses the term "limited duty" for medical restrictions as a result of a workrelated injury and "light duty" for medical restrictions due to other conditions not related to the job.

1. *Form CA-17, Duty Status Report*

Form CA-17, Duty Status Report is the form the employee's attending physician uses to list any work limitations or restrictions that the employee may have as a result of the work injury. The agency may only contact your physician in writing in regards to such limitations or restrictions. If there are any changes as a result of this contact, then a new Form CA-17 must be prepared by the employing agency and provided to the physician, to the employee and to OWCP.

2. Light Duty Offers

Based on the medical restrictions stated by the physician, the agency can make a light duty offer. Offers can be made verbally but must be followed-up in writing. A copy of the offer must be sent to OWCP for the claims examiner to review. OWCP determines if it is appropriate.

The light duty offer must include:

- the job description
- the physical demands of position
- the organizational and geographical location

- the date the position is available
- the date a response is required from the employee

It will usually also include information about the salary and grade as well as any work accommodations available.

OUR ADVICE

Make sure the employee meets the deadline for responding to management. The offer letter will usually include language that if there is no response by a certain date, the agency will consider that a refusal.

The employee has 15 days to notify OWCP in writing if the employee cannot accept the light duty offer. The employee must explain the reasons why the offer is not suitable and show that the refusal is reasonable. For example, if the employee feels that the light duty position will not conform to the medical restrictions placed by the doctor, the employee will have to explain to OWCP how the duties conflict with the medical restrictions. The employee should also ask his or her doctor to review the light duty offer and include the doctor's medical opinion in support of the employee's reasons for refusing the offer. Other than medical, there are few other reasons OWCP would accept refusal of a light duty offer.

If OWCP determines that the employee's refusal is unreasonable, the employee's benefits will be terminated.

B. RETENTION RIGHTS

If an injured or ill employee recovers within one year of starting compensation, he or she has the right to return to the old position or a similar one. Retention rights are covered by 5 CFR §§353, 302, and 330, and they are administered by the Office of Personnel Management, not OWCP.

If the agency refuses to re-employ an employee who has recovered after suffering a compensable injury or illness, the agency is required to notify the employee in writing of his or her right to appeal to the Merit Systems Protection Board (MSPB).

C. DISABILITY RETIREMENT

If it is determined that an employee can no longer work, it is in the employee's best interest to apply for continued OWCP benefits and Civil Service disability retirement simultaneously. If both are approved, the employee can choose the one that best serves his or her needs. In general, OWCP benefits are more beneficial for employees.

CHAPTER 6

THE APPEALS PROCESS

The filing of CA-1 or CA-2 will normally result in a formal OWCP decision of acceptance or denial. If a claim is denied by OWCP, the employee has several options. The employee can request an oral hearing or a review of the written record, reconsideration or appeal to the Employees' Compensation Appeals Board (ECAB). OWCP decisions will provide details regarding the employee's hearing, reconsideration and appeal rights. The employee will have to notify OWCP of his or her decision to appeal by returning the appeals form attached to the letter of denial within the timeframe specified for each type of appeal.

A. HEARING

Employees have 30 days from the date of an OWCP District Office denial to request an oral hearing from the Branch of Hearings and Review in Washington, DC. They may request instead that they perform a review of the written record, with no oral testimony.

1. Oral Hearing

The oral hearing is an informal proceeding and the employee has the chance to present his or her case to the hearing representative in person. OWCP offers claimants the option to have their hearings held over the phone.

OUR ADVICE

While phone hearings may be more convenient in some situations, it is more beneficial to try to have an oral hearing. However, it may take six months to a year, or longer, after the employee's request for an oral hearing to get a decision. The length of the delay depends primarily on how soon a hearing representative from Washington, DC, is assigned.

As the employee's representative, you can represent him or her in the hearing. You can help the member prepare for the hearing by reviewing the course of events, making sure the documentation is accessible and in order, and reviewing their job description. You can also help by guiding the questioning at the hearing. As with any other proceeding with management, advise the employee to "stick to the facts" and leave out irrelevant information. A vital part of preparation is helping the member decide what is and is not relevant.

2. Review of the Written Record

The review of the written record is a second look at the file to determine if the decision made is the right one. It is usually done by a claims examiner other than the one who denied the case. It is the policy of the Branch of Hearings and Review to provide a decision regarding a review of the written record within 90 days.

B. RECONSIDERATION

Employees may also, within one year of any OWCP or Appeals Board decision, request reconsideration (a review) from any OWCP District Office. In order to secure District Office reconsideration, new and detailed relevant evidence (usually medical) must be submitted. The employee can also make a new argument not considered by OWCP, or show that OWCP made a mistake or wrongly applied the law.

Employees cannot have an oral hearing or review of the written record by the Branch of Hearings and Review if they have already received an OWCP reconsideration decision. The policy of OWCP is to provide a decision on a request for reconsiderations within 90 days.

OUR ADVICE

Employees should first request an oral hearing. This is a hearing before a representative of OWCP held near the employee's residence. Doing this first gives the employee the option of requesting reconsideration later if his or her appeal is denied.

C. EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)

Employees have 180 days from the date of any formal OWCP merit decision to appeal to the Employees' Compensation Appeals Board (ECAB).

ECAB hearings are held in Washington, DC. No new evidence can be presented at the hearing. The local union representative can represent the claimant if necessary. Claimants are usually asked whether they will make a personal appearance before the Board or send their argument in writing. The agency can be present but cannot participate in the proceedings unless asked by the hearing panel, the claimant or the claimant's representative.

If the local union representative will represent the employee before the ECAB, it is important to be prepared to answer questions about the case. The representative should have the case file, preferably in chronological order, and be prepared to point out information that may have been overlooked in making the decision to deny the case.

For ECAB appeals, decisions may take up to two or three years. ECAB decisions are precedent-setting, which means they serve to guide decisions in future cases.

CHAPTER 7

HOW THE UNION HELPS MEMBERS

The union has no duty of fair representation when it comes to workers' compensation matters. However, once we agree to take on representation, we should provide the highest level of service possible. Also, because there is no duty of fair representation, we can restrict our services in this area to members only. It is also an opportunity to encourage employees to join the union.

The union's primary function in the workers' compensation process may be to educate members and to provide information on the claims process. The local union should educate members on the provisions of the Federal Employees Compensation Act (FECA) and the specific requirements of OWCP. Knowing how it works and what is expected of them helps workers to better deal with a process that can be overwhelming. Understanding their rights and responsibilities helps them comply with the requirements and will help the process go smoothly.

Another important function of the local union in workers' compensation is to help members to fill out the forms required to file and support a claim. Although management is charged under FECA with helping employees through the process, we find that employees are often on their own. This is especially true when there are problems in the development phase of the claim and the information OWCP requests is not sent in by the employee or the agency. Once claims are denied, the process becomes more difficult and lengthy.

In some cases the workers' compensation representative may have to file on behalf of an employee who is unable to do so. For example, the employee may have been struck by something and become unconscious or the employee may have to be rushed to the emergency room. Remember that anyone can file on behalf of an employee, including the AFGE representative or steward.

The union workers' compensation representative may also be the first to raise workers' compensation eligibility to the attention of the injured employee, and sometimes even management. The union's role should be to encourage employees to file for workers' compensation benefits if they are eligible and to report unsafe or unhealthy conditions.

The local union may also have to intervene or advocate on behalf of its members both with management and OWCP. Some management practices may be damaging to not only to a specific employee but workers in general. In those situations, the local union should work to bring about changes that are more equitable to employees. In addition, the local union must enforce any language in its collective bargaining agreement that covers workers' compensation. If the agency is not



meeting its contractual obligations, the local union may have to mobilize members, seek congressional involvement or file a grievance. Some things agencies do to make it difficult for injured employees run counter to FECA regulations. The Department of Labor (DOL) is responsible for enforcing OWCP regulations. If DOL fails to enforce the regulations, the local union might have to address these situations through a mobilization campaign, legislative action or the grievance procedure.

The Workers' Compensation Representative

The local union workers' compensation representative has several roles in the claims process: Educator, representative, mediator, advocate, liaison and supporter.

The representative's role will also include making sure that employees know their responsibilities, which include:

- Promptly reporting work-related injuries and illnesses to the supervisor
- Filling out forms within specified times
- Providing required documentation
- Reporting for medical determination if the agency requires it for placement after injury.

The representative should also be familiar with the rights and responsibilities of management in the claims process. Management responsibilities include:

- Providing information and forms to injured and ill employees
- Processing claims in a timely manner
- Providing light/limited duty positions when medically indicated
- Publicizing information on where to report incidents and file claims
- Notifying the union when an employee is injured.

The work of the local union workers' compensation representative may include:

- Helping the member understand the filing process.
- Helping the member fill out forms and write the narrative.
- Helping the member respond to agency and OWCP requests for information, particularly helping the employee obtain the appropriate medical reports from physicians.

AFGE representatives, officers and stewards often work in the same locations as employees who either suffer traumatic injuries or occupational illnesses. You are familiar with the work and the working conditions and can better assist members with their workers' compensation claims. As a workers' compensation representative, this can be especially helpful in writing the narrative for the claims form. Some representatives may have suffered workplace injuries or illnesses and may be familiar with the claims process from a claimant's perspective.

In order to be recognized as a representative by OWCP, the claimant must designate the union representative in writing. There is no specific form to use. You can use a standard representation form or the employee can write a letter naming the union representative as his or her representative for the workers' compensation case. As the claimant's designated representative, you will receive copies of correspondence OWCP sends to the claimant. Remember that workers' compensation documents are covered by the Privacy Act. OWCP forms have the privacy information printed on the instructions page.

In addition, you may help the member monitor progress on the claim. Claims can take a long time, especially when information is not provided in a timely manner during the development process. The representative may have to remind employees that the process timeline can be lengthy, depending on the injury or illness. Stress claims, for example, often take the longest to be adjudicated.

When a claim is accepted, the representative may be called upon to help the employee buy back any leave he or she may have taken while waiting for the claim to be adjudicated. Although we encourage employees to use COP when eligible, some may not for private reasons. Others may have had to use their own leave because they filed a CA-2 for an occupational illness or disease, which is not eligible for COP.

While a claim is ongoing, you might help the member negotiate and arrange accommodations he or she needs to remain at work. Issues may arise with schedules when the agency wants to move an employee to a different shift or denies the employee's request for a change. You may have to rely on requests for reasonable accommodation under the Rehabilitation Act of 1973 or any specific language in your collective bargaining agreement. You may also be requested to help employees with the appeals process, which can include helping them request the appeals option that is best for them or representing them in the actual hearing.

When disabled employees can no longer meet the requirements of their jobs, you might have to advise employees on retirement options.

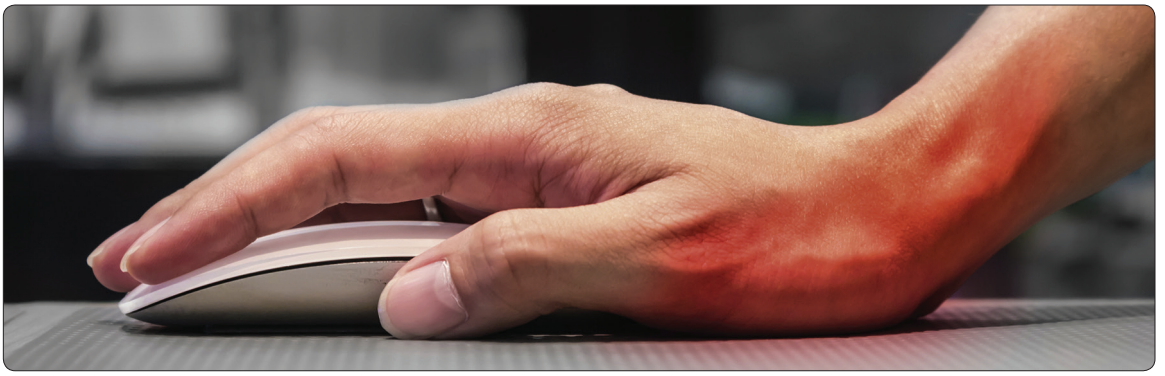
Although not directly related to workers' compensation, the local can also inform individuals who run out of leave about possible eligibility under the agency's leave donation program. The local can also help employees request donations among the membership.

Using WC Representation in Organizing

The most important reason to become involved in workers' compensation is to help members. Once your local decides to offer this representation to members and establish your expertise, you can and should use it to strengthen your organizing efforts. Since there is no duty of fair representation with workers' compensation, the union is not required to represent employees who are not dues-paying members. You can choose to offer representation only to members. However, it may be more beneficial to encourage employees who seek your help to become members. Sometimes you may choose to represent a potential member in order to prevent injustices or to protect the rights of the bargaining unit.

Here are some ideas on using workers' compensation representation in organizing:

- Publicize your ability to help with the workers' compensation process: Let members know there is someone at the local who can help them fill out forms, respond to OWCP requests for information and advise them on doctors' reports required by OWCP. Include a brief write-up



in your publications or make a presentation at your next membership meeting.

- Hold a lunch and learn to review the workers' compensation process and how to report injuries and illnesses at your workplace.
- Recruit new members for the health and safety and/or workers' compensation committee.
- Inform the membership of changes you were able to effect by being involved. For example, you find that management is not being timely in submitting claims to DOL. You bring this issue to the attention of management and follow-up to make sure claims are being submitted. The fact that you are staying on top of it may result in claims being submitted in a timelier manner.
- Conduct a brief survey among the membership to learn about their health and safety concerns. You may find potential hazards that can be addressed before someone gets hurt.

Improving Health and Safety

Another important way to grow the local union through workers' compensation is to focus on improving health and safety. This area directly affects most employees. Reason: Because while not everyone will need to file for workers' compensation, everyone benefits from improved working conditions. Local unions can play a significant role in helping to prevent workplace injuries and illnesses.

Helping members with workers' compensation claims and staying involved in this area within your agency will also help the local better understand the hazards present in the workplace. Over time, patterns will emerge and you will see which departments, which shifts and which occupations have a high number of workers' compensation claims.

In addition to the workers' compensation cases you handle, you should also get information from the agency on the claims being filed by your bargaining unit. It can be a summary report of the claims filed in the last month or the last quarter. The report should include the type of claim, the type of condition claimed and whether there was any lost work time. Some bargaining agreements call for notification to the union when a bargaining unit member files claim. Some agencies give locals copies of the claim with the identifying information redacted.

It is in the best interest of the local and its membership to get complete information. Knowing the areas in the workplace where employees are getting hurt or sick, and which body parts are affected will help you better advocate for workplace improvements.

Locals should also review injury and illness records, that is, the agency's OSHA 300 log, where agencies are required to record reportable injuries and illnesses. If your

agency is not regularly providing this information, ask for it.

OUR ADVICE

Check your bargaining agreement. Many contracts include language about the injury and illness data that the agency will provide to the union. If yours does not, make sure it is on your list of items to include in the next contract negotiation.

It is a requirement of 29 CFR 1960 for the agency to post summary information for the past year in a place accessible to all employees. All employees have the right under OSHA's recordkeeping standard to see the OSHA 300 log. The union has the right to review and make copies of the log.

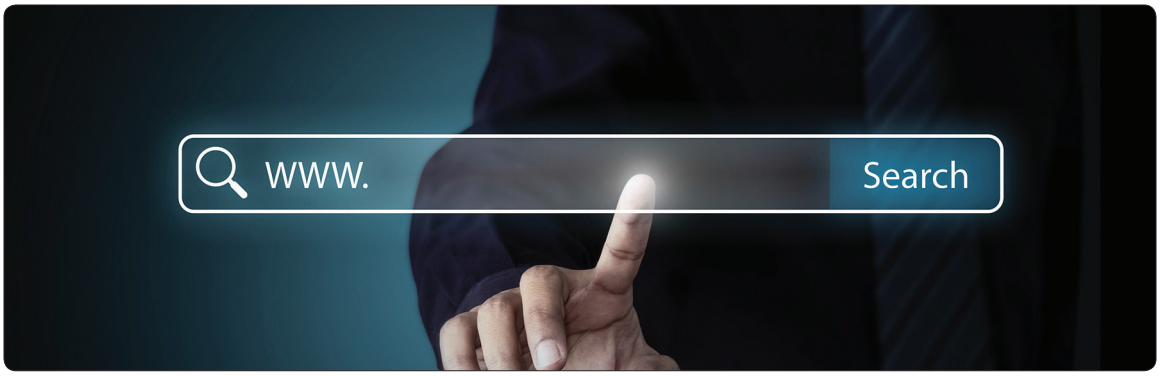
How can the local be more active in health and safety?

If you find a pattern or trend in injuries and illnesses, bring it to the attention of management. Don't assume management is aware, although it is possible that management knows and has not done anything to address the issue. However, the local union raising a concern puts it in the forefront and puts management on notice that the local union expects action. If possible, propose ways to address the issues you raise. Involve the membership in finding solutions. You will find that employees usually have the best ideas for resolving workplace health and safety problems.

If there is a joint labor-management committee, make sure the local is an active participant. Raise issues, bring ideas for training, propose solutions, and participate in inspections.

If you don't have a union health and safety committee, establish one. The union committee discusses problems, gets input from the membership and decides which issues to bring to the joint committee.

Be vigilant about developments in these two areas: workers' compensation and health and safety. While management has legal and statutory obligations in these areas, the union at all structural levels--local, council, district, and national--also has the responsibility of protecting the rights and entitlements of its members.



CHAPTER 8

RESOURCES

At the Department of Labor/OWCP website, you can get copies of all OWCP forms, except for the CA-16, the Authorization for Medical Treatment. The CA-16 has to be issued by an authorized official of the employing agency.

Some forms can be completed on line, but must be printed, signed, and submitted; they cannot be saved with the filled-in information or submitted electronically. Your agency, however, may have electronic submission on its own website, as discussed in Chapter 4. Copies of the most commonly used forms are included in Appendix B for your information.

Many agencies use DOL's ECOMP for electronic filing. Claimants can use ECOMP to upload documents such as medical reports directly to their claim files

You can also get the addresses and telephone numbers of the district office that handles cases in your state as well as the central mailing address for all OWCP. These are listed in Appendix A.

In addition, you can download copies of OWCP publications. We recommend the following documents:

- **Publication CA-11:** When Injured at Work Information Guide for Federal Employees
- **Publication CA-550:** Questions and Answers about the Federal Employees' Compensation Act
- **Publication CA-810:** Injury Compensation for Federal Employees: This is a more technical document to guide federal agencies in their handling of workers' compensation claims.
- **Program Procedures and Policy Guidance:** These are the documents that claims examiners use in their processing of claims.
- **ECAB Decisions:** These provide insight into the process and how cases are reviewed and decided. Reviewing decisions can help in learning what to do and what not to do in helping members with their appeals.

On the OWCP website there are online training programs that you can use to review the information covered in this manual and to learn more about FECA and the claims process.

OWCP also has an Interactive Voice Response System (IVR) at **866-OWCP-IVR (866-692-7487)** that allows claimants to check on medical authorization requests and status of bill payment. To speak with a customer service representative about medical bills or authorizations, requires a toll call to **(850) 558-1818.**

There is also an on-line tool: http://owcp.dol.acs-inc.com/portal/main.do. This is a link to ACS, the contractor that handles medical bills

for OWCP. The Claimant Query System, which provides case status information, can also be accessed through the ACS website.

OWCP claim status information is also available on the the Employee Personal Information page at the National Processing Center, a payroll payment center used by some agencies. More information on this is available on the OWCP website. If the employee's agency participates in one of these two systems, employees can check on the status of their claims after they have logged in as they would normally.

OTHER RESOURCES

You may also check out AFGE website –- National, District, Council, and Local resources are available through our main website at ***www.afge.org/healthsafety***. There you will find manuals, factsheets, and a list of frequently asked questions, among other resources.

In addition, other AFL-CIO affiliated federal worker unions, such as the American Postal Workers Union at ***www.apwu.org*** and the National Association of Letter Carriers at ***www.nalc.org*** have workers' compensation information on their websites. The NALC, for example, has several articles dealing with specific topics in workers' compensation.

Federal agency websites also post information for injured workers that can be useful to anyone going through the process. First, check out the employing agency's website and its intranet, or the website for employees only. Many post workers' compensation claim forms, information on how the agency processes claims, and who to contact for help. Also, look at the websites of other agencies to learn more.

Other sites include CyberFeds at ***www.cyberfeds.com***, a subscription service that has a separate workers' compensation section with information on OWCP, ECAB decisions, and copies of the FECA regulations, and Government Executive at ***www.govexec.com***, an electronic newsletter that has news articles on workers' compensation. There are also federal workers' compensation associations, and other injured worker groups that provide information and guidance on the issue.

APPENDIX A

CENTRAL MAILROOM AND
DISTRICT OFFICES

Central Mailroom Address: (Commonly referred to as "the London, KY address")

U.S. Department of Labor
DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

** Contact information is subject to change.*

District Office 1 – Boston
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

District Director (857) 264-4600

U.S. Dept. of Labor, OWCP
JFK Federal Building, Room E-260
Boston, MA 02203

(857) 264-4600
(857) 264-4602 (Fax)

Acommodation line: (857) 264-4605

District Office 2 – New York
New Jersey, New York, Puerto Rico, and the Virgin Islands

District Director (212) 863-0800

U.S. Dept. of Labor, OWCP
201 Varick Street, Room 740
New York, NY 10014

DFEC: (212) 863-0800
World Trade Center cases: (646) 264-3030
DFEC Fax: (212) 863-0801
Longshore: (646) 264-3010
(646) 264-3002 (Fax)

Acommodation line: (212) 863-0802

District Office 3 – Philadelphia
Delaware, Pennsylvania, and West Virginia; Maryland except claimants who reside in an area roughly comprising Prince George's County

District Director (267) 687-4160

U.S. Dept. of Labor, OWCP
Curtis Center, Suite 715 East
170 S. Independence Mall West
Philadelphia, PA 19106-3308

(267) 687-4160
(267) 687-4155 (Fax)

Acommodation line: (267) 687-4162

District Office 6 – Jacksonville
Alabama, Florida, Georgia, Kentucky, Mississippi, No. Carolina, So. Carolina, and Tennessee

District Director (904) 366-0100

U.S. Dept. of Labor, OWCP
Charles E. Bennett Federal Building
400 West Bay Street, Room 826
Jacksonville, FL 32202

(904) 366-0100
(904) 366-0101 (Fax)

Acommodation line: (904) 366-0102

District Office 9 – Cleveland
Indiana, Michigan, Ohio; All special claims and all areas outside the U.S., its possessions, territories and trust territories

District Director (216) 902-5600

U.S. Dept. of Labor, OWCP
1240 East Ninth Street, Room 851
Cleveland, OH 44199

(216) 902-5600
(216) 902-5601 (Fax)

Acommodation line: (216) 902-5602

District Office 10 – Chicago
Illinois, Minnesota, Wisconsin

District Director (312) 789-2800

U.S. Dept. of Labor, OWCP
230 South Dearborn Street, Eighth Floor
Chicago, IL 60604

(312) 789-2800
(312) 789-2801 (Fax)

Acommodation line: (312) 789-2802

District Office 11 – Kansas City
Arkansas, Iowa, Kansas, Missouri, and Nebraska; all employees of the Department of Labor, except Job Corps enrollees, and their relatives

District Director (816) 268-3040

U.S. Dept. of Labor, OWCP
Two Pershing Square Building
2300 Main Street, Suite 1090
Kansas City, MO 64108-2416

(816) 268-3040
(816) 268-3041 (Fax)

Acommodation line: (816) 268-3042

District Office 12 – Denver
Colorado, Montana, New Mexico, No. Dakota, So. Dakota, Utah, and Wyoming

District Director (303) 202-2500

U.S. Dept. of Labor, OWCP
P.O. Box 25602
One Denver Federal Center, Bldg 53
Denver, CO 80225-0602

(303) 202-2500
(303) 202-2501 (Fax)

Acommodation line: (303) 202-2502

District Office 13 – San Francisco
Arizona, California, Hawaii, and Nevada

District Director (415) 241-3300

U.S. Dept. of Labor, OWCP
90 Seventh St., Suite 15-100F
San Francisco, CA 94103

(415) 241-3300
(415) 241-3301 (Fax)

Acommodation line: (415) 241-3302

District Office 14 – Seattle
Alaska, Idaho, Oregon, and Washington

District Director (206) 470-3100

U.S. Dept. of Labor, OWCP
300 Fifth Avenue, Suite 1050F
Seattle, WA 98104-2429

(206) 470-3100
(206) 470-3101 (Fax)

Acommodation line: (206) 504-5195

District Office 16 – Dallas
Louisiana, New Mexico, Oklahoma, and Texas

District Director (214) 749-2320

U.S. Dept. of Labor, OWCP
525 South Griffin Street, Room 100
Dallas, TX 75202

(214) 749-2320
(214) 749-2321 (Fax)

Acommodation line: (214) 749-2322

District Office 25 – Washington, D.C.
District of Columbia, Virginia; Maryland when the claimant's residence in an area roughly comprising Prince George's County

District Director (202) 513-6800

U.S. Dept. of Labor, OWCP
800 N. Capitol Street, N.W., Room 800
Washington, D.C. 20211

(202) 513-6800 (D.C., Maryland and Virginia)
(202) 513-6806 (Fax)

Acommodation line: (202) 513-6802

APPENDIX B

LIST OF FORMS

Form	*Title*
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
CA-2	Notice of Occupational Disease and Claim for Compensation
CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
CA-7	Claim for Compensation on Account of Traumatic Injury or Occupational Disease
CA-7a	Time Analysis Form
CA-7b	Leave Buy-Back (LBB) Worksheet/Certification and Election
CA-16	Authorization for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report (attached to Form CA-7; also available separately)
CA-35, a-h	Occupational Disease Checklists
OWCP-1500a	Health Insurance Claim Form

OWCP Most Often Used Forms

Form	Title	Use	Employee Timeline	Agency Timeline
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation	Traumatic injury, occurs within one work shift	Within 30 days of injury to get COP; up to 3 years, but should file as soon as possible	Submit to OWCP within 10 workdays of receipt from employee
CA-2	Notice of Occupational Disease and Claim for Compensation	Long-term or chronic illness or disease	As soon as employee realizes it's work-related, up to 3 years.	Submit to OWCP within 10 workdays of receipt from employee
CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation	After returning to work, the employee needs to stop work or needs more medical treatment due to the injury	As soon as possible	Immediately when received from employee
CA-7	Claim for Compensation on Account of Traumatic Injury or Occupational Disease	Request compensation for wage loss	In traumatic injury cases, submit 10 days before the end of COP; for occupational disease cases, as soon as pay stops	Give employee form on 30th day of COP. Due to OWCP on 40th day of COP. Submit to OWCP within 5 days of receipt
CA-16	Authorization for Examination and/or Treatment	Guaranties payment of medical care after traumatic injury	Obtain as soon as possible, within 4 hours; Doctor submits after initial exam	Within 4 hours of injury
CA-17	Duty Status Report	Provides information on ability to return to work	Get from doctor after exam	As soon as exam is done
CA-20	Attending Physician's Report (attached to Form CA-7; also available separately)	Provides medical support for claim	Get from doctor after initial exam	As soon as exam is done
CA-35a-h	Occupational Disease Checklists	Provides medical support for specific conditions	As soon as doctor fills out; submit with CA-2	Within 10 work days of receipt from employee; submit with CA-2
OWCP-1500a	Health Insurance Claim Form	Standard billing form	Doctor submits; employee signs	Not applicable

APPENDIX C

OWCP FORMS

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Reset Print

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

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth Mo. Day Yr.
4. Sex ☐ Male ☐ Female
5. Home telephone
6. Grade as of date of injury Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
10. Date injury occurred Mo. Day Yr. / Time ☐ a.m. ☐ p.m.
11. Date of this notice Mo. Day Yr.
12. Employee's occupation
13. Cause of injury (Describe what happened and why)
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code
b. Type code
c. Source code
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

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

Signature of employee or person acting on his/her behalf _____ **Date** _____

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

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

Witness Statement

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

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Form CA-1
Rev. Apr. 1999

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

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code)

OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

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

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

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

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

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

25. Date pay stopped Mo. Day Yr.

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

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

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

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

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

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

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

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

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

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

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

37. Pay rate when employee stopped work $: Per

Signature of Supervisor and Filing Instructions

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor

Date

Supervisor's Title

Office phone

39. Filing instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Form CA-1
Rev. Apr. 1999

Notice of Occupational Disease and Claim for Compensation

Reset Print

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 M
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)
8. 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 I 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 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.

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

Form CA-2
Rev. Jan. 1997

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 date medical care received Mo. 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

Form CA-2
Rev. Jan. 1997

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

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

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

Receipt of Notice of 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.

Form CA-2

Reset Print

Notice of Recurrence

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

OMB No. 1215-0167
Expires: 05-31-2011

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.

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? (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.
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)

Form CA-2a
Rev. Sept. 1996

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)

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 Mo. Day Yr. From 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? _____

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. Furnishing the requested information is required to obtain and retain benefits 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

Reset Print

Claim for Compensation

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

SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee — Last | First | Middle

OMB No. 1215-0103
Expires: 09/30/2011

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

c. OWCP File Number

d. Date of Injury Month Day Year

e. Social Security Number

E-Mail Address (*Optional*)

f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

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

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

☐ Yes — Name and Address of Business:

☐ No *Go to section 4*

Name | Address | City | State | ZIP Code

Dates Worked: | Type of Work:

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

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

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

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

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

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

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

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

Name | Address | City | State | ZIP Code

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

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

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

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

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

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

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

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

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

Form CA-7
Rev. June 2005

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

SECTION 8 Show Pay Rate as of

Date of Injury:	Base Pay	Additional Pay	Additional Pay	Additional Pay
Date:	$ per	Type $ per	Type $ per	Type $ per
Grade: Step:				
Date Employee Stopped Work:		Type $ per	Type $ per	Type $ per
Date:	$ per			
Grade: Step:				

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

SECTION 9

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

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

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

FOR EXAMPLE ONLY

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

	S	M	T	W	TH	F	S
WEEK 1 From to							
WEEK 2 From to							

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

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

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

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

b. Basic Life Insurance? ☐ No ☐ Yes

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

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

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

From To

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

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

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

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

If Yes, date

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

☐ Yes ☐ No If No, explain:

SECTION 14 Remarks:

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

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

Signature Title Date / /

(*Agency Official*)

Name of Agency

Date Claim Form Recieved from Employee / /

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

Name Title

Telephone No. Fax No. E-Mail Address

Time Analysis Form Reset Print

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

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

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

4. Period Covered by This Form:	5. Total Hours Claimed
From: To:	for LWOP: for Leave BuyBack

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

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

Signature of Claimant Date Signed

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

Signature of Agency Official Date Signed

Form CA 7a
June 1996

Leave Buy Back (LBB) Worksheet/
Certification and Election

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

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

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

D. Period for Which Compensation is Claimed to Repurchase Leave

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

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate *(excluding overtime)*

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

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

_____ / _____ / _____
(effective date)

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

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

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

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

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

F. Total Hours Worked per Week 9. _____

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

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

Form CA 7b
June 1996

II. Agency Certification:

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

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

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

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

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

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

_____ (Signature of Agency Official)

_____ (Title/Position)

Phone No _____ Date Signed: _____

Employing Agency Address for Check: _____

_____

_____

III. Employee Claim:

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

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

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

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

_____ (Signature of Claimant)

_____ (Date Signed)

Page 2

Duty Status Report

Reset | Print

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

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

OMB No. 1215-0103
Expires: 09-30-2011

OWCP File Number (If known)

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

1. Employee's Name (Last, first, middle)
2. Date of Injury (Month, day, yr.)
3. Social Security No.
4. Occupation
5. Describe How the Injury Occurred and State Parts of the Body Affected
6. The Employee Works
   Hours Per Day ____ Days Per Week ____
7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)
9. Description of Clinical Findings
10. Diagnosis Due to Injury
11. Other Disabling Conditions
12. Employee Advised to Resume Work?
    ☐ Yes, Date Advised ____ ☐ No
13. Employee Able to Perform Regular Work Described on Side A?
    ☐ Yes, If so ☐ Full-Time or ☐ Part-Time ____ Hrs Per Day
    ☐ No, If not, complete below

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

t. Other (Describe)

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)
15. Date of Examination
16. Date of Next Appointment
17. Specialty
18. Tax Identification Number
19. Physician's Signature
20. Date

Form CA-17
Rev. Jan. 1997

Submit Reset Print

Attending Physician's Report

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

Record of Examinaton

1. Patient's name * Last	First	Middle	2. Date of Injury * mo, day yr	3. OWCP File Number *	OMB No. 1215-0103 Expires: 09-30-2011

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

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

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

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

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

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

13. What treatment did you provide?

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

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

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

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

25. Remarks

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

Signature

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

Signature of Physician: Signature — Date *

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

Form CA-20
Rev. Nov. 1999

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

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

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

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

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

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DOL DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

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