BY ORDER OF THE
SECRETARY OF THE AIR FORCE

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Personnel

INJURY COMPENSATION

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This publication implements Air Force Policy Directive (AFPD) 36-1, *Appropriated Funds Civilian Management and Administration;* and supplements Department of Defense Instruction (DoDI) 1400.25, Volume 810, *DoD Civilian Personnel Management System: Injury Compensation.* The DoDI is printed word-for-word in regular font without editorial review. Department of the Air Force (DAF) supplementary material is printed in bold font and indicated by "(Added)(DAF)." This publication prescribes procedures and delegates authority for implementing the DAF injury compensation (IC) program. The program provides compensation to DAF civilian employees for disability due to personal injury, disease, or death arising from or within the scope of their employment, in accordance with (IAW) the Federal Employees' Compensation Act (FECA), section 8101 of Title 5, United States Code (5 U.S.C.). This publication applies to all appropriated funded DAF civilian employees, to include Regular Air Force, United States Space Force (USSF), Title 5 Air National Guard and Title 5 Air Force Reserve civilian employees. It does not apply to: nonappropriated fund employees; non-US citizen employees employed outside the United States; to Title 32 Air National Guard Technicians or Title 5 National Guard Employees, as they are not serviced by the Air Force Personal Center Injury Compensation Office. The Chief of the National Guard Bureau develops personnel policy for the National Guard Injury Compensation Program. In collaboration with the Chief of Air Force Reserve (AF/RE), the Director of the Air National Guard (NGB/CF), and the Deputy Chief of Space Operations for Human Capital (SF/S1), the Deputy Chief of Staff for Manpower, Personnel, and Services (AF/A1) develops personnel policy for the DAF injury compensation program. Refer recommended changes, questions or comments about this publication to the office of primary responsibility (OPR) listed above using the DAF Form 847, *Recommendation for Change of Publication*; route DAF Forms 847 from the field through the appropriate chain of command. The authorities to waive wing, unit, or delta level requirements in the DAF supplement portion of this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See DAF manual (DAFMAN) 90-161, *Publishing Processes and Procedures*, for a description of the authorities associated with the tier numbers. Submit requests for waivers through the chain of command to the appropriate tier waiver approval authority, or alternately to the requestor's commander for

non-tiered compliance items. This publication may be supplemented at any level; all Major Command (MAJCOM), Field Command (FLDCOM) or corresponding Secretariat, Air Staff and Office of the Chief of Space Operations level supplements must be approved by the Human Resource Management Strategic Board prior to certification and approval. All supplements that directly implement this publication must be routed to the OPR for coordination. Ensure that all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. This instruction requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by DoDD 5400.11, DoD Privacy Program. The application SORN, OPM/GOVT-1, General Personnel Records, applies and is available at http://dpclo.defense.gov/Privacy/SORNs.aspx . The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the DAF.

SUMMARY OF CHANGES

This document has been revised to add appropriate considerations and terminology due to the stand-up of the USSF. Rewrite also incorporates updated references and publication guidance. Rewrite removed some sections of the supplement which were duplicates of information in the DoDI portion of the publication. Additional changes include: overall grammatical changes and updated responsibility verbiage in Enclosure 2, paragraphs 12-14, including the addition of AF/A1X coordination with AF/A1C in the financial responsibilities for the program.

Department of Defense
INSTRUCTION

NUMBER 1400.25-V810
April 12, 2005
Administratively reissued April 16, 2009

USD(P&R)

SUBJECT: DoD Civilian Personnel Management System: Injury Compensation

References: See Enclosure 1

1. PURPOSE

a. Instruction. This Instruction is composed of several Volumes, each containing its own purpose. The purpose of the overall Instruction is to establish and implement policy, establish procedures, provide guidelines and model programs, delegate authority, and assign responsibilities regarding civilian personnel management within the Department of Defense.

b. Volume. This Volume of this Instruction implements DoD policy, prescribes procedures, and delegates authority on implementing the DoD injury compensation program under the "Federal Employees' Compensation Act" (FECA), section 8101 of title 5, United States Code (U.S.C.), (Reference (a)) which provides benefits to civilian employees of the Federal Government for disability due to personal injury, disease, or death arising from or within the scope of their employment.

2. APPLICABILITY. This Volume applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter collectively referred to as the "DoD Components").

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy under Reference (b) to:

a. Ensure that DoD employees are entitled to a safe and healthful work environment that complies with the DoD safety and health policies identified in Reference (c).

b. Provide prompt medical attention and full assistance in claiming just compensation for injuries or occupational illnesses incurred in the performance of their duties. Supervisors and

managers shall:

(1) Create a culture of safety consciousness.

(2) Make every effort through light duty programs and reemployment.

(3) Ensure that all involved in the program, including private sector medical personnel, are aware of these programs.

(4) Investigate and take appropriate action on fraud and abuse in the program.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3.

7. RELEASABILITY. UNLIMITED. This Volume is approved for public release and is available on the Internet from the DoD Issuances Web Site at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Volume is effective immediately.

(Added)(DAF) Approved by: JOHN A. FEDRIGO,
Principal Deputy Assistant Secretary (Manpower and Reserve Affairs)

Enclosures:
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2. Responsibilities
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Glossary

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REFERENCES

(a) Sections 552a, 5545, 5546, 8101, 8105, 8106, 8107, 8112, 8115, 8119, 8122, 8124, 8128, 8129, 8131, 8133, 8134, 8140, 8147, 8148, 8149, 8344, and 8468 of title 5, United States Code
(b) DoD Directive 1400.25, "DoD Civilian Personnel Management System," November 25, 1996
(c) DoD Instruction 6055.1, "DoD Occupational Safety and Health Program," August 19, 1998
(d) Title 20, Code of Federal Regulations, current edition
(e) Sections 5545, 8344, and 8468 of title 5, United States Code
(f) Section 651 of Public Law 104-208, September 30, 1996
(g) Deputy Assistant Secretary of Defense/Civilian Personnel Policy Memorandum, November 8, 1996, "Death Gratuity Payment" (hereby canceled)
(h) Sections 286, 287, and 1001 of title 18, United States Code
(i) Under Secretary of Defense for Personnel and Readiness Memorandum, "Injury Compensation Program Administration," June 13, 2003 (hereby canceled)
(j) Title 29, Code of Federal Regulations, Part 20, Subpart D, sections 1614 and 1910.95, current edition
(k) Under Secretary of Defense for Personnel and Readiness Memorandum, "Injury Compensation Automated Data Systems," July 23, 2003 (hereby canceled)
(l) OPM "Guide to Processing Personnel Actions," December 31, 1998
(m) Section 1910.95 of title 29, Code of Federal Regulations, "Occupational Noise Exposure," current edition
(n) Section 5546, title 5, United States Code
(o) Title 5, Code of Federal Regulations, Parts 550 and 551, current edition
(p) Title 5, Code of Federal Regulations, Part 550, Subpart M, "Pay Administration (General)," current edition
(q) "FECA Procedure Manual," April 1995
(r) Title 29, Code of Federal Regulations, Part 20, Subpart D, "Federal Claims Collection," current edition
(s) OPM Operating Manual, Section 102 of the Civil Service Retirement System and Federal Employees Retirement System Handbook for Personnel and Payroll Offices, April 1998
(t) (Added)(DAF) Air Force Policy Directive 36-1, "Appropriated Funds Civilian Management and Administration," March 18, 2019
(u) (Added)(DAF) Department of the Air Force Manual 90-161, "Publishing Processes and Procedures," April 15, 2022
(v) (Added)(DAF) Air Force Instruction 33-322, "Records Management and Information Governance Program," March 23, 2020
(w) (Added)(DAF) Department of the Air Force Instruction 36-147, "Civilian Conduct and Responsibility," 30 August 2018

(Added)(DAF) Adopted Forms
DAF Form 847*, Recommendation for Change of Publication*
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-10*, What a Federal Employee Should Do When Injured at Work*

ENCLOSURE 2

RESPONSIBILITIES

1. CIVILIAN PERSONNEL MANAGEMENT SERVICE (CPMS). The CPMS is responsible for:

a. Providing operational guidance, advice, and assistance concerning injury compensation matters.

b. Developing, enhancing, and maintaining a standard enterprise-wide civilian HR system for injury compensation program management (June 13, 2003 "Injury Compensation Program Administration" memorandum, (Reference (i)) that:

(1) Uses standardized processes and procedures to streamline operations and ensure data integrity.

(2) Contains appropriate safeguards for the protection of sensitive medical, personnel, and payroll data.

c. Reviewing and approving in advance any plans from DoD Components to incorporate workers' compensation data elements into new or existing automated reporting systems (Reference (i)).

2. SUPPORTING DoD LIAISONS. The supporting DoD liaisons, in or near the 12 OWCP district offices, shall:

a. Establish and nurture a good working relationship with DOL.

b. Provide assistance and guidance to serviced activities, as needed.

c. Serve as central point of contact between serviced activities and the OWCP district offices, and other concerned offices.

d. Review OWCP case files for accuracy, legitimacy, medical evidence, reemployment potential and questionable case status.

e. Conduct staff assistance visits to activities within assigned districts.

f. Assist in the training of ICPA's.

g. Provide assistance in activity reemployment efforts by reviewing job offers and advocating approval by DOL.

h. Attempt to resolve disagreements between DOL and serviced activities informally.

i. Participate in installation FECA meetings.

j. Receive and execute all chargeback corrections from DoD Installations.

k. Coordinate and arrange for all district office file review visits by ICPA's.

3. ORGANIZATIONS ONE LEVEL ABOVE INSTALLATION LEVEL AND COMPARABLE ORGANIZATIONS. Organizations one level above installation level (i.e., MACOMS (Army), Major Claimants (Navy), MAJCOMs (Air Force) and comparable organizations that have a directorate of civilian personnel or human resources assigned must ensure that the injury compensation program is effectively administered in CPOs/HROs. A staff member is designated as the ICPA. Headquarters level ICPA's monitor numbers and types of injuries and associated costs (including COP). The ICPA coordinates with higher headquarters' level safety and medical offices for technical advice and assistance in improving work environments and developing cost containment initiatives.

4. ACTIVITY COMMANDER. The Activity Commander ensures:

a. The CPO/HRO, as well as the appropriate regional service center, has a staff member designated as the ICPA.

b. Management responsibilities under the commander's authority are timely fulfilled with delays held to a minimum.

c. Employees are advised of their rights and responsibilities under the Injury Compensation Program and that compensation claim forms are made available to employees.

d. Maximum effort is made to keep injured employees on the job and that light duty positions are made available.

e. Maximum effort is made to restructure positions for employees who have been permanently or partially disabled because of a job-related injury or illness. The "reasonable accommodation" (see Glossary for definition) provisions of 29 CFR 1614 (Reference (j)) apply to the Injury Compensation Program.

f. The FECA Working Group meets periodically (usually quarterly) to analyze FECA costs, trends, plans, etc., and develop cost containment initiatives. FECA Working Groups shall consist of management, safety, personnel, medical, and investigative services staffs. FECA Working Groups are mandatory.

5. ACTIVITY MEDICAL SERVICE

a. Medical Officers. Medical officers review all reported cases of occupational illness and take or recommend action. Upon the ICPA's request, they:

(1) Provide medical information to be sent to OWCP to support or to controvert a claim for an occupational illness or work-related injury.

(2) Communicate with the employee's personal physician, in writing, to clarify medical evidence when ICPA's attempts fail.

(3) Conduct a medical review of controversial and complex cases.

(4) With the treating physician's recommendations, participate with the CPO/HRO in returning employees to duty as soon as medically feasible.

(5) Assist the ICPA in informing the local medical community of FECA program and problems being experienced.

(6) Review, evaluate, and recommend light-duty assignments and make recommendations on employee placements involving work limitations.

(7) Advise the attending physician, in writing, that the medical facility may give supportive treatment such as physical therapy, under his or her direction (arrangements should be made with the concurrence of the employee and attending physician).

(8) Provide a representative to actively participate in the activity FECA Working Group.

b. Occupational Heath Officials. Occupational health officials (industrial hygiene, public health, epidemiology, etc.) shall:

(1) Receive notice that an occupational disease or illness claim has been filed. This notice must not compromise the protection of sensitive medical, personnel, or payroll data.

(2) Provide workplace exposure monitoring and epidemiology data appropriate for investigation.

(3) Advise workplace managers and supervisors of the result of the exposure monitoring, and recommended workplace practices to control worker exposure (i.e., process changes, material substitution, engineering controls, personal protective equipment, administrative controls, and worker training).

(4) Provide a representative to actively participate in the activity FECA Working Group.

6. ACTIVITY SAFETY OFFICES. The Activity Safety Offices shall:

a. Investigate all reported job-related injuries and prepare required reports.

b. When requested by the ICPA, provide information to be sent to OWCP to support or to controvert a claim for compensation.

c. Provide a representative to actively participate in the activity FECA Working Group.

d. Provide safety training, as required.

e. In conjunction with the CPO/HRO, identify positions/duties for light duty assignments.

7. ACTIVITY INVESTIGATIVE SERVICE. Activity Investigative Service personnel assigned to the activity shall:

a. When requested by the ICPA through appropriate channels, conduct an investigation of the specified claim to determine and document evidence of fraud.

b. Provide a written report of findings of the investigation through appropriate channels to the ICPA.

c. Provide a representative to actively participate in the activity FECA Working Group.

8. FIRST-LINE SUPERVISORS. First-line supervisors shall:

a. Enforce safety and health regulations.

b. Ensure that the location and telephone number of emergency medical facilities are made known at the work site.

c. Ensure that employees know when and how to report occupational injuries and illnesses.

d. Obtain training in, and have a good understanding of, the Electronic Data Interchange (EDI) application when filing claims for injuries and illnesses under FECA (July 23, 2003, "Injury Compensation Automated Data Systems" memorandum (Reference (k)).

e. Ensure that employees know they have the freedom to choose a treating physician (see paragraph 11.j. of Enclosure 2), and send injured employees for medical treatment when a traumatic injury is reported. If an employee refuses treatment, document the facts of the situation as reported and investigate as necessary;

f. Ensure COP is reported accurately and completely for time and attendance purposes.

g. In conjunction with the CPO/HRO's staffing employment division, identify positions or duties to make light duty offers.

h. Ensure doctors are notified in writing of possible duty accommodations.

i. Report all injuries and illnesses promptly to the ICPA.

j. Promptly complete injury compensation forms and send them to the ICPA.

k. Report injuries and illnesses as required by governing safety regulations.

l. Make decisions regarding whether to controvert COP based on information available.

m. Maintain continued personal contact with the injured employee as the disability warrants.

n. Enforce safety regulations and the wearing of required protective equipment and clothing and take appropriate disciplinary action against employees for failure to comply.

o. (Added)(DAF) DAF has centralized IC processing so supervisors are assigned the responsibility reflected in paragraph 10.b. of this publication and will ensure DOL Form CA-10, *What a Federal Employee Should Do When Injured at Work,* (Figure 1) is posted at the worksite, to provide instruction on what to do in case of an injury/occupational illness. (T-3).

p. (Added)(DAF) Direct the injured employee to the Employees' Compensation Operations & Management Portal (ECOMP) to electronically initiate the compensation claim; access ECOMP link and complete supervisor section of the claim; and ensure original signatures are obtained and submitted to the Air Force Personnel Center, Injury Compensation Office (AFPC/ICO) (T-3). As applicable, obtain signed statements from witnesses to the injury. Contact the AFPC/ICO for assistance regarding any aspect of the IC program.

q. (Added)(DAF) Advise the AFPC/ICO if supervisor feels that an investigation is warranted. (T-3). Contact assigned Injury Compensation Specialist (ICS) for questions concerning if continuation of pay is authorized and the proper coding of timecards. (T-3). NOTE: For the purpose of this publication, the title ICS and Injury Compensation Program Administrator (ICPA) are synonymous.

9. CIVILIAN EMPLOYEES. Civilian employees shall:

a. Promptly and accurately report all job-related injuries or illnesses to their supervisors, unless prevented from doing so by the severity of the injury. If an employee is unable to report an injury or illness, anyone, such as a friend, relative, co-worker, or supervisor may report for the employee. Employees on TDY should report job-related injuries or illnesses to their servicing CPO/HRO by the best available means. If that is impossible, they may report them to the nearest DoD CPO/HRO.

b. Observe all safety instructions, procedures, and regulations to include the proper use of personal protective equipment and clothing.

c. Report for medical examination or treatment as described by established procedures or as directed by their supervisors.

d. Advise the treating physician of light duty programs.

e. Advise supervisor when they are medically released for light duty.

f. Provide medical documentation as soon as possible, but no later than 10 working days, or COP may be discontinued.

g. Return to regular or light duty as soon as medically feasible.

h. Participate in vocational and job related training designed to provide suitable alternate employment when job-connected injury or illness precludes return to previous type of work.

i. (Added)(DAF) Report injury and, if elected, initiate compensation claim(s) in ECOMP. (T-3). In event employee is incapacitated the supervisor may initiate the claim

by registering in ECOMP and submit the claim using the injured worker's SSN. The AFPC/ICO will advise the supervisor on how to file the claim in ECOMP on the employee's behalf to ensure subsequent submission to the Office of Workers' Compensation Programs (OWCP). (T-3).

j. (Added)(DAF) Immediately provide to supervisor and the AFPC/ICO, copies of any medical documentation that provide work restrictions. (T-3).

k. (Added)(DAF) Provide statements, facts, and relevant information regarding the injury, without misrepresentation. (T-3). Employees who provide false or intentionally misleading information in this process may be subject to civil or administrative remedies as well as felony criminal prosecution, with a fine or imprisonment or both authorized as punishments.

10. INJURY COMPENSATION PROGRAM ADMINISTRATOR (ICPA). The ICPA serves as the focal point in all aspects of the program, coordinating efforts of safety officials, occupational health officials, medical officials, supervisors and other management officials, and local labor representatives, as appropriate. To ensure optimum effectiveness in the administration of the program, it is imperative that the ICPA maintain a professional and cooperative relationship in his or her contacts with the OWCP district offices, supporting DoD liaisons, activity personnel and the injured worker. The ICPA shall:

a. Provide training and operational guidance to supervisors and employees concerning their responsibilities within the injury compensation program.

b. Ensure that Form CA-10 (poster), "What a Federal Employee Should Do When Injured at Work" (Figure 1) is posted at the work site.

c. Maintain a working knowledge of the Electronic Data Interchange (EDI) application, ensure that supervisors are trained in, and have a good understanding of the application, and utilize EDI when filing claims for injuries and illnesses under FECA (Reference (k)).

d. When notified about a job-related injury or illness or an actual or potential claim, give prompt help to the supervisor and the employee. The ICPA shall ensure that pertinent forms are properly and timely completed. (The ICPA is not responsible for the accuracy of information provided and entered on forms by the employee, supervisor, or witnesses, but must obtain clarification of conflicting or confusing statements.) NOTE: The ICPA has the final responsibility for the technical adequacy of all documents sent to OWCP.

e. Upon receipt of a Form CA-1 or Form CA-2, check the form for completeness. If there is any doubt about the information shown on the form, the ICPA will resolve the matter before further processing. The electronic version of Forms CA-1 and CA-2 contain an Authorization for Release of Information. If necessary, the ICPA can require the employee to sign and date an Authorization for Release of Information. A sample is at Figure 2. Because there is a short-time limit (10 working days or less) on processing injury compensation forms, any necessary action should be taken on a priority basis.

f. When appropriate, the ICPA will request that safety or medical services furnish, in writing, a report on the claim and include this information with the claim when sending it to

OWCP. If this would cause an undue delay, this information can be sent to OWCP at a later date. Both safety and medical services officials may, of their own volition, initiate letters or other documents to accompany claims. After determining that all forms are correct and reflect the correct chargeback account code, the ICPA sends them to OWCP.

g. If the injury results in no medical expense and no lost time, the Form CA-1 or Form CA-2 is permanently filed in the Employee Medical File (EMF) and no copy is sent to the OWCP. The ICPA should send notification to the activity safety office that a traumatic injury or occupational disease or illness claim has been filed. This notice must not compromise the protection of sensitive medical, personnel, and payroll data.

h. In prolonged COP cases, the ICPA will ensure that a Form CA-7 is completed and sent to the OWCP, no later than 5 calendar days before the COP period expires (if the claimant wishes to file for compensation).

i. When the injured employee is absent from duty, the supervisor, ICPA, and medical officials estimate the earliest date that the employee should be reasonably able to return to full-time or part-time light or regular duty based on medical evidence deemed appropriate by OWCP. On that date, if the employee has not returned, and the employee has not provided medical evidence to support continued absence, the supervisor contacts the employee to learn the reason. The ICPA shall contact the attending physician in writing to inquire about restrictions and estimated return to light duty and/or the servicing OWCP office for an expected date of return to duty. If the employee is still not able to return to duty, a new estimated return date is established, and the procedure is repeated until the employee is returned to duty. It is important for physicians to understand that supervisors can and will accommodate restrictions imposed by medical officials.

j. Assist supervisors and employees in all aspects of the Injury Compensation Program, including, electronic and paper forms completion and case follow-up with the OWCP.

k. Maintain adequate records to administer the program and reconstruct claim files, if necessary. A copy of all documents sent to OWCP should be retained in the activity claims file.

l. Monitor COP days to ensure they do not extend beyond the 45-calendar day period.

m. Periodically, compare COP payments in the civilian pay activity with the claim status shown in the ICPA's records to assure accuracy.

n. Establish procedures to ensure that all claims (CA forms) and related documents are processed to or through the office of the ICPA.

o. If light duty is a possibility, ensure that job requirements and environmental conditions are made known to physicians when injured or ill employees or former employees are scheduled for examinations.

p. Notify OWCP and furnish documentation of any pre-existing medical condition that might be useful in adjudicating a claim.

q. Refer suspected fraud cases through channels to the proper military investigative authority, DOL Inspector General (IG), or other investigative services. Contact the supporting DoD liaison for any needed assistance.

r. Notify the selective placement coordinator of employees requiring placement assistance.

s. Coordinate with the activity legal office on claims that appear to involve third-party liability.

t. Ensure that an ample supply of required forms is maintained and available to employees and supervisors, as needed.

u. If an employee dies as the result of a job-related injury, immediately notify OWCP, by telephone, fax, or telegraph, and send a completed Form CA-6, "Official Supervisor's Report of Employee's Death," to OWCP within 30 calendar days from the date death occurred.;

v. Attend pre-scheduled meetings of the Occupational Safety and Health Council or other similar activity. The ICPA must be prepared to discuss the Injury Compensation Program.

w. Annually, initiate requests for review of selected long-term claim files and request current medical reports from the supporting DoD liaison to:

(1) Ensure that claimants receive compensation benefits for which they are entitled.

(2) Identify claimants who can return to work. Those claimants who have been formally determined by OWCP as having no wage-earning capacity or reemployment potential for the indefinite future are identified by OWCP as a PN status case. PN claimants are required by OWCP to furnish medical documentation of continued disability once every 3 years; therefore, copies of medical reports for these claimants should be requested on a 3-year basis instead of an annual basis. Claimants receiving payments for loss of wage-earning capacity are required to furnish medical documentation every 2 years. Note: OWCP makes PN status determinations. It is inappropriate and costly for agencies to request OWCP to change the pay status of a case to PN without a sound and clearly defined basis. All such requests must be sent with accompanying justification to the supporting DoD liaison who will assist with agency requests.

x. Maintain a file of names of physicians who have been excluded from payment under FECA. (The OWCP makes this determination and provides the list.) The ICPA shall ensure that activity officials who issue Form CA-16 are kept informed of the names and changes on that list.

y. Work with rehabilitation counselors and the activity staffing function on reemployment referrals and work with OWCP-directed field nurses on return to duty under the Nurse Intervention Program.

z. Verify claimant information received from OWCP in the "Defense Injury & Unemployment Compensation System (DIUCS)"(see paragraph 2.d.(3) of Enclosure 3), electronic notifications through EDI, and on Form CA-801, "Acknowledgment of Receipt of Claim." Immediately ask OWCP to correct erroneous information. All erroneous chargeback

code corrections should be requested through the supporting DoD liaison.

aa. Verify program reporting information and certify the accuracy of all charges and chargeback codes received from OWCP using "Defense Injury & Unemployment Compensation System (DIUCS)" reports (see paragraph 2.d.(3) of Enclosure 3), and the "Defense Portal Analysis Center (DefPAC)." Immediately request that supporting DoD liaisons coordinate the correction of erroneous data with OWCP.

ab. Certify the accuracy of all charges and chargeback codes on the DOL Quarterly Chargeback Billing Lists and report any errors to the supporting DoD liaison. (Detailed instructions for correcting erroneous data is further explained in section 10 of Enclosure 3, "The Injury Compensation Chargeback System.").

ac. Serve as a chairperson or as an active participant in the activity FECA Working Group.

ad. Contact the supporting DoD liaisons for assistance with unique and unusual problematic issues.

11. PROVIDING COUNSEL AND ASSISTANCE. One of the primary functions of the ICPA is to provide counsel and assistance to injured employees as well as to supervisors. When an employee sustains a job-related injury or illness, the ICPA shall explain to the employee the basic benefits provided under FECA:

a. Entitlement to compensation for injuries or illnesses sustained in the performance of duty: 66-2/3 percent of basic salary for employees without dependents; 75 percent for employees with dependents.

b. The importance of providing written notice of injury and timely submission of forms and related documentation.

c. Entitlement to COP for a traumatic injury up to a maximum of 45 calendar days. If the injury extends or is expected to extend beyond the 45-day COP period, the employee should be informed of the proper procedure to claim wage loss (Form CA-7). Explain the 3-day waiting period (see Glossary for definition).

d. The difference between use of sick and annual leave versus COP for Form CA-1, item 15; who approves COP and how COP days are counted. If COP is disallowed by OWCP, explain that money paid is considered a debt and is subject to recovery.

e. The difference between benefits under workers' compensation and Federal disability retirement, if eligible (Figure 3).

f. For employees separating from employment, the consequence of withdrawing retirement contributions. Provide the employee a copy of the notice to individuals with funds in the civil service retirement system (Figure 4).

g. Adjudication of claims by the Department of Labor, OWCP. The employing activity acts only as an intermediary in gathering information pertinent to the claim and submitting it to OWCP. Decisions made by OWCP can be appealed by the employee.

h. Leave buyback procedures when an employee does not wish to immediately file for compensation, the claim has been approved by OWCP, and the COP period has expired or there is no entitlement to COP. If applicable, explain the 3-day waiting period.

i. The penalties provisions as detailed in paragraph 1.k. of Enclosure 3, "Penalties for Employees and Supervisors."

j. An employee has the right to select his or her own physician, as long as the physician is located within 25 miles of the employee's place of employment or residence and is not on the list of excluded medical providers. However, if the employee wants to change the physician, after the initial selection has been made, written justification must be provided and prior approval obtained from OWCP.

k. The importance (requirement) that OWCP authorization is needed before extensive tests, hospitalization, or surgery.

l. Procedures for filing for medical and travel expenses.

m. Death benefits to survivors in fatality cases.

12. (Added)(DAF) THE ASSISTANT SECRETARY OF THE AIR FORCE FOR MANPOWER AND RESERVE AFFAIRS (SAF/MR). Serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets addressing the administration of civilian personnel matters.

13. (Added)(DAF) THE DEPUTY CHIEF OF STAFF FOR MANPOWER, PERSONNEL, AND SERVICES (AF/A1). Develops, coordinates, and executes personnel policy and essential procedural guidance for the management of DAF civilian IC policy.

14. (Added)(DAF) THE DIRECTOR, CIVILIAN FORCE MANAGEMENT (AF/A1C). Under the authority and direction of the AF/A1, and in coordination with the SF/S1, AF/A1C:

a. (Added)(DAF) Directs development and implementation of DAF civilian IC policy policy, monitors programs and assesses implementation to ensure DAF compliance with statute, regulation, Department of Defense policy and this instruction. Provides guidance on provisions of this instruction.

b. (Added)(DAF) In coordination with AF/A1X, provides oversight for IC funding as the Program Element Monitor; and gathers budgetary, program, and historical data to prepare source and requirements charts justifying budget submissions, monitoring use of funds and approving reimbursements, authorizing transfer of funds between accounts, requesting and justifying need for additional funds, or explaining return of funds not expended.

c. (Added)(DAF) In coordination with AF/A1X, calculates payments for each base/activity and ensures payment to DOL through the Defense Finance and Accounting Service (DFAS) within 30 days of approval of appropriations for the applicable fiscal

year.

15. (Added)(DAF) <u>AIR FORCE PERSONNEL CENTER, INJURY COMPENSATION OFFICE (AFPC/ICO)</u>. Executes the DAF IC program and assists eligible civilian employees, previously and currently assigned to DAF bases within and outside the Continental U.S., who claim work-related injuries and occupational diseases. Air Force Personnel Center Injury Compensation Specialists administer the program and provide direct servicing for and administration of the IC program. AFPC/ICO:

a. (Added)(DAF) Receives and processes all claims for traumatic work-related injuries and occupational diseases and illnesses; reviews compensation claims for benefits to ensure medical documentation is provided and all requirements for initiating claims are met; and processes claims to the OWCP within 14 calendar days of receipt so a decision can be rendered on employees' eligibility for benefits.

b. (Added)(DAF) Provides support and guidance to Base Commanders, the injured worker, his or her family and or representatives, the injured workers' supervisor, the base Employee and Management Relations Specialist/CPO, and on and/or off base medical staff. Serves as the point of contact for questions, intervenes when circumstances necessitate additional involvement in a claim, and maintains a working knowledge of the Department of Labor's (DOL) ECOMP system in order to instruct supervisors and employees on how to utilize the system to complete the required compensation forms.

c. (Added)(DAF) Provides operational guidance and policy interpretation, advises and educates managers, supervisors, employees, employee representatives, medical and safety staff, and any other officials or authorized personnel on the provisions of the program, and coordinates with safety and medical offices for technical advice and assistance in improving work environments and developing cost containment initiatives.

d. (Added)(DAF) Monitors DAF-wide numbers, types of injuries and associated costs, including continuation of pay, reviews the DOL chargeback report identifying medical and compensation expenditures for accuracy, prepares reports and statistical information, and prepares and provide reports for each base for presentation to the FECA Working Group, or other formal advisory group that convenes for the purpose of discussing IC matters.

e. (Added)(DAF) Assists in identifying fraudulent claims, conducts reviews of all claim and refer those with indicators of fraud or abuse to the appropriate action office; initiates appropriate action when results of investigation substantiate fraud, waste and/or abuse in accordance with DAFI 36-147, *Civilian Conduct and Responsibility* and applicable laws.

f. (Added)(DAF) Publicizes information regarding the IC program on-line through all available official DAF websites and ensures significant information concerning fraudulent claims, costs, and other compensation related matters is published in an effort to curtail compensation costs.

g. (Added)(DAF) Ensures the development and use of a Fraud, Waste and Abuse Checklist in connection with each OWCP claim file as a means of screening against fraud

indicators and warning signals. The ICS will include a copy of this checklist in the case file to indicate that they have considered warning signals or fraud/abuse indicators in accordance with Enclosure 3 of Department of Defense Instruction 1400.25-V810, *Department of Defense Civilian Personnel Management Syste*m: *Injury Compensation*. (T-0).

h. (Added)(DAF) Provides data/reports to Base Commanders on a quarterly basis, based on the most recent quarterly chargeback report. Data may include information such as current costs/trends, number of new claims, cause of injury, nature of injury, injury description, number of claimants working less than full time, and associated continuation of pay costs including claimants who have separated from the base. Data/reporting is intended to be used by the FECA Working Group to address and manage IC costs. Additional data for trend analysis could be grouped by base, organization and nature of injury with the associated medical and compensation costs.

i. (Added)(DAF) The AFPC/ICO is tasked with operational management of the DAF IC program, to include creating a comprehensive operational plan to provide assistance to injured employees while also containing costs. This plan should include the following areas:

(1) (Added)(DAF) Training. Ensure that AFPC/ICO personnel who handle compensation claims receive training in relevant technical and managerial skills. (T-1).

(2) (Added)(DAF)Administration. Establish a recordkeeping system in accordance with reference (v), to maintain copies of claim forms, medical reports, correspondence with OWCP, and other materials related to each compensation claim in an orderly fashion.

(3) (Added)(DAF) Documentation. Ensure that the facts surrounding each injury are adequately investigated at the time of injury. This investigation will ensure the OWCP is provided all available information upon which to render decisions regarding coverage under the FECA.

(4) (Added)(DAF) Medical. Obtain medical information from the OWCP or the injured employees as often as needed to assess the possibility of return to regular or light duty. Advise physicians of any available light duty assignments and their specific requirements to provide the best possible chance for reemployment.

(5) (Added)(DAF) Reemployment. The AFPC/ICO maintains contact with injured claimants while they are receiving compensation, identifies jobs suitable for them, and initiates efforts to reemploy recovered or recovering claimants as soon as the medical evidence indicates that this is possible.

(6) (Added)(DAF) Financial. Monitors DAF-wide numbers, types of injuries and associated costs, including Continuation of Pay costs, associated with reported injuries and claims. Conscientious application of the above principles will result in monetary savings and better service to injured employees. The chargeback system is the mechanism by which the costs of compensation for DAF claimant work-related injuries and deaths is charged to the Component.

16. (Added)(DAF) BASE COMMANDER OR EQUIVALENT. IAW paragraph 4 of Enclosure 2, ensures a viable and compliant IC program that:

a. (Added)(DAF) Emphasizes the importance of a safe working environment in all aspects of the organization, ensures employees and their supervisors are aware that claims are to be filed directly through the ECOMP, and endorses training for managers and supervisors. (T-3).

b. (Added)(DAF) Creates a culture which promotes accountability, establishes appropriate internal controls to minimize fraud, ensures roles and responsibilities are clear, and provides a safe, anonymous way for employees to report suspected abuse and support investigations for suspected fraud. (T-3).

c. (Added)(DAF) Supports the return to work programs by ensuring maximum efforts are made to keep injured employees on the job, on light duty, or restructure positions for employees who have been permanently or partially disabled because of a job-related injury or illness. (T-3).

d. (Added)(DAF) Establishes a FECA Working group. The FECA Working Group:

(1) (Added)(DAF) Maintains oversight of the IC fraud, waste and abuse efforts and will be informed by the AFPC/ICO of any trends or other significant indicators suggestive of FECA fraud. (T-3).

(2) (Added)(DAF) May use administrative inquiries and audits to assist in cost reduction. These inquiries help determine if fraud, waste and abuse has occurred and if an investigation is warranted. (T-3).

(3) (Added)(DAF) Supports managerial and supervisory injury compensation and annual refresher training, and keep members and management current regarding procedures, trends, and return to work initiatives. (T-3).

(4) (Added)(DAF) Ensures meeting minutes are sent to the Civilian Personnel Flight for review and distribution. (T-3). An appointed FECA Working Group secretary should maintain meeting minutes for historical record of working group decisions and accomplishments.

(5) (Added)(DAF) Receives briefings from the base Safety Office concerning the injuries, illnesses or occupational diseases that have occurred during the period under review, with a focus on any injuries, illnesses or occupational diseases that resulted in one or more lost days. (T-3). These briefings will address the causes of the injury, illness or occupational disease, lessons learned and efforts to prevent a similar future incident. (T-3).

17. (Added)(DAF) CIVILIAN PERSONNEL SECTION (CPS).

a. (Added)(DAF) Supports the AFPC/ICO by keeping management and employees informed of the IC program including current processes and future program updates. (T-3).

b. (Added)(DAF) Trains, participates in, and/or supports training for supervisors and managers. (T-3).

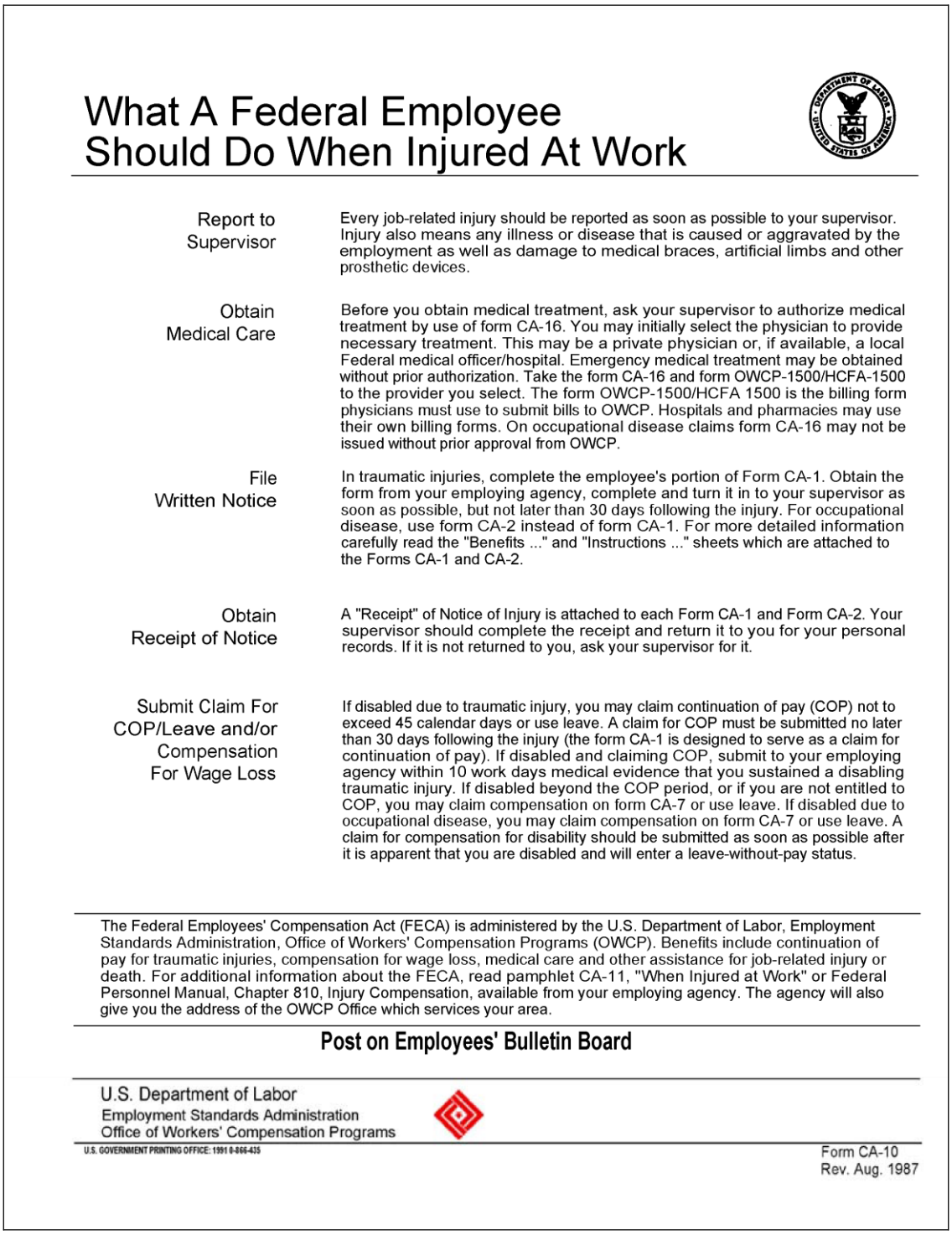
c. (Added)(DAF) Coordinates with supervisors on accommodation and return to work requests. (T-3).

d. (Added)(DAF) Provides a base-wide search for a position that may match the abilities of an injured worker no longer physically qualified for their date of injury position. (T-3).

APPENDIX TO ENCLOSURE 2

FIGURES

Figure 1. Form CA-10, "What A Federal Employee Should Do When Injured At Work"



What A Federal Employee Should Do When Injured At Work

Report to Supervisor

Every job-related injury should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices.

Obtain Medical Care

Before you obtain medical treatment, ask your supervisor to authorize medical treatment by use of form CA-16. You may initially select the physician to provide necessary treatment. This may be a private physician or, if available, a local Federal medical officer/hospital. Emergency medical treatment may be obtained without prior authorization. Take the form CA-16 and form OWCP-1500/HCFA-1500 to the provider you select. The form OWCP-1500/HCFA 1500 is the billing form physicians must use to submit bills to OWCP. Hospitals and pharmacies may use their own billing forms. On occupational disease claims form CA-16 may not be issued without prior approval from OWCP.

File Written Notice

In traumatic injuries, complete the employee's portion of Form CA-1. Obtain the form from your employing agency, complete and turn it in to your supervisor as soon as possible, but not later than 30 days following the injury. For occupational disease, use form CA-2 instead of form CA-1. For more detailed information carefully read the "Benefits ..." and "Instructions ..." sheets which are attached to the Forms CA-1 and CA-2.

Obtain Receipt of Notice

A "Receipt" of Notice of Injury is attached to each Form CA-1 and Form CA-2. Your supervisor should complete the receipt and return it to you for your personal records. If it is not returned to you, ask your supervisor for it.

Submit Claim For COP/Leave and/or Compensation For Wage Loss

If disabled due to traumatic injury, you may claim continuation of pay (COP) not to exceed 45 calendar days or use leave. A claim for COP must be submitted no later than 30 days following the injury (the form CA-1 is designed to serve as a claim for continuation of pay). If disabled and claiming COP, submit to your employing agency within 10 work days medical evidence that you sustained a disabling traumatic injury. If disabled beyond the COP period, or if you are not entitled to COP, you may claim compensation on form CA-7 or use leave. If disabled due to occupational disease, you may claim compensation on form CA-7 or use leave. A claim for compensation for disability should be submitted as soon as possible after it is apparent that you are disabled and will enter a leave-without-pay status.

The Federal Employees' Compensation Act (FECA) is administered by the U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs (OWCP). Benefits include continuation of pay for traumatic injuries, compensation for wage loss, medical care and other assistance for job-related injury or death. For additional information about the FECA, read pamphlet CA-11, "When Injured at Work" or Federal Personnel Manual, Chapter 810, Injury Compensation, available from your employing agency. The agency will also give you the address of the OWCP Office which services your area.

Post on Employees' Bulletin Board

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

U.S. GOVERNMENT PRINTING OFFICE: 1991 0-866-435

Form CA-10
Rev. Aug. 1987

Figure 2. "Authorization for Release of Information" Form

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

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

Figure 2. "Authorization for Release of Information" Form, Continued

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

Figure 2. "Authorization for Release of Information" Form, Continued

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

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

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

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

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury.

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee Is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-1
Rev. Apr. 1999

Figure 2. "Authorization for Release of Information" Form, Continued

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 benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.

(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 defringement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

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 office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

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 Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

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

*U.S. GPO: 1999-454-845/12704

Form CA-1
Rev. Apr. 1999

Figure 3. Comparison-Workers' Compensation vs. Disability Retirement

COMPARISON
WORKERS' COMPENSATION VS DISABILITY RETIREMENT

WORKERS' COMPENSATION	VS	DISABILITY RETIREMENT
1. Must have total or partial disability or permanent impairment of a scheduled member or function of the body.		1. Need only be disabled for current position and no equivalent position is available which the employee is capable of performing.
2. Injury or illness must be job-related.		2. Disability does not have to be job-related
3. 66 2/3 percent of service pay without dependents or 75 percent of pay with dependents when totally disabled. If partially disabled, reduced benefits.		3. Depends on the length of service as a Federal employee, the age of the employee, and the retirement system. The servicing personnel office has specific information regarding the entitlement.
4. No minimum service required.		4. Need five years civilian service (CSRS) or 18 months (FERS) to apply for disability retirement.
5. Tax free.		5. Taxable.
6. Periodic examinations are required.		6. Periodic examinations are required.

Figure 810-3. Workers' Compensation vs. Disability Retirement

Figure 4. "Notice to Individuals with Funds in the Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS)"

NOTICE TO INDIVIDUALS WITH FUNDS
IN THE CIVIL SERVICE RETIREMENT SYSTEM (CSRS)
OR FEDERAL EMPLOYEES RETIREMENT SYSTEM (FERS)

The Federal Employees' Compensation Act (FECA) is not a retirement system. Your award of compensation is subject to change or termination if a change occurs in your job-related medical condition or if other evidence is received showing that adjustment or termination of benefits is necessary. Should it become necessary to reduce or terminate your compensation payments in the future, you may wish to elect Civil Service Retirement System or Federal Employees' Retirement System benefits. Once your employment is terminated, applications for disability retirement must be filed within one year. In the event of your death, compensation is not payable to your survivors unless they can establish that your death is the result of the accepted job-related medical condition.

The U.S. Office of Personnel Management (OPM) administers the retirement systems. OPM has asked that you be reminded of the temporary nature of FECA disability compensation payments and of the job-relatedness requirement for payment of FECA death benefits. If you remove your contributions from the Retirement Fund, you lose all entitlement to a Civil Service annuity and your survivors lose all entitlement to a Civil Service survivorship annuity. If you have any questions about the consequences of taking a refund of your retirement contributions, please contact your servicing personnel office and read the information contained with the application for a refund of your retirement deductions. Be sure to get the form that applies to you: SF-2802 for employees under the Civil Service Retirement System and SF-3 106 for employees under the Federal Employees Retirement System.

ENCLOSURE 3

PROCEDURES

1. AUTHORITIES

a. Statutory Authorities. The DoD Injury Compensation Program is based on FECA and the rules and regulations of the U.S. Department of Labor Office of Workers' Compensation Programs under 20 CFR (Reference (d)). Claim forms referred to herein are covered by the Privacy Act of 1974 (Reference (a)). Records are authorized by FECA.

b. The Federal Employees' Compensation Act (FECA), as amended. FECA provides monetary compensation, medical care and assistance (attendant allowances), vocational rehabilitation, and reemployment rights to Federal employees who sustain disabling injuries as a result of their Federal employment. FECA also provides for a fixed payment for the deceased employee's funeral expenses and for compensation benefits to qualified survivors of the decedent in cases of employment-related death. In 1974, FECA was amended, increasing benefits and significantly changing the law by adding provisions such as continuation of pay (COP) and claimant's choice of physician.

c. Federal Employees' Compensation Program Financing. FECA program is financed by the Employees' Compensation Fund, which consists of funds appropriated by Congress directly, or indirectly, through a chargeback to the various agencies. Each year, the Secretary of Labor furnishes a statement to each DoD Component of payments made from the Fund. These costs are charged back to each DoD Component. The DoD Components include FECA costs in their budget requests and use the resulting sums to reimburse the Fund for these charges.

d. Department of Labor (DOL) Involvement. In 1908, President Theodore Roosevelt signed legislation to provide workers' compensation for certain Federal employees in unusually hazardous jobs. The scope of the law was very restricted and its benefits were quite limited. However, it was the first workers' compensation law to pass the constitutionality test of the United States Supreme Court. FECA, enacted in 1916, superseded the 1908 statute. An independent quasi-judicial Employees' Compensation Commission was created to administer the law. In 1950, DOL assumed administrative responsibility for FECA. FECA is now administered by the Office of Workers' Compensation Programs (OWCP), Employment Standards Administration, U.S. Department of Labor.

e. DoD Involvement. As costs of workers' compensation benefits continue to grow, the need for a consolidated approach by all DoD Agencies to reduce costs and to improve program management has become necessary. Each Civilian Personnel Office /Human Resources Office (CPO/HRO) will designate a staff member as Injury Compensation Program Administrator (ICPA) to oversee the program, to coordinate the efforts of all involved management officials, and to ensure optimum effectiveness in program administration.

f. Basic FECA Requirements. To qualify for benefits, the employee or employee's survivors must establish that the injury or employee's death met the requirements:

(1) Time. For injuries and deaths which occurred before September 7, 1974, different provisions apply with respect to timeliness. ICPA's are to contact the supporting DoD liaison to obtain assistance before making a pre-September 7, 1974, timeliness determination. For injuries or deaths on or after September 7, 1974, Reference (a) requires that a claim for compensation must be filed within 3 years of the injury or death. Even if the claim is not filed within 3 years, compensation may still be allowed if written notice of injury was given in 30 days or the immediate supervisor had actual knowledge of the injury or death within 30 days of occurrence.

(2) Civil Employee. If the claim is timely filed, it must be determined whether the injured employee or deceased employee was an employee within the meaning of the law. It covers all civilian Federal employees, whether permanent or temporary, except for nonappropriated fund employees. Federal employees who are not citizens or residents of the United States or Canada are covered subject to certain special provisions governing their pay rates and computation of compensation payments. Determinations for other employees must be made on a case-by-case basis once a claim is filed.

(3) Fact of Injury. It must be established whether the employee in fact sustained an injury or disease. Two factors are involved in this third determination. Did the employee actually experience the accident, event, or employment factor which is alleged to have occurred? Did the accident or employment factor result in an injury or disease?

(4) Performance of Duty. If the first three criteria have been accepted, it must be determined whether the employee was engaged in the performance of duty when the injury occurred. The question of where and when the accident, event, or employment factor(s) leading to filing of a claim occurred must be studied.

(5) Causal Relationship. After the four factors aforementioned are considered, causal relationship between the condition claimed and the injury or disease sustained is examined. This factor is based entirely on medical evidence provided by physicians who have examined and treated the employee. Sometimes the circumstances of a case raise the issues of willful misconduct, intention to bring about the injury or death of oneself or another, or intoxication. If any of these factors is established as the cause of the injury or death, benefits must be denied.

g. FECA Benefits. Employees may be eligible for six basic types of benefits under FECA: Medical benefits (including transportation expenses incurred); Continuation of Pay; Disability compensation; Schedule awards; Vocational rehabilitation; and, Death benefits that include allowable funeral benefits and survivor compensation. The program applies to any disability (temporary or permanent, partial or total) incurred as a result of a job-related disease or condition, as well as an on-the-job traumatic injury.

(1) Medical Benefits. Payment may be made for any medical services needed for treatment or to counteract or minimize the effects of any condition, disease, or injury determined to be causally related to employment with the Federal Government. There is no limit on the extent of medical treatment payable, nor is there a time limit for which they are payable if the need for medical treatment can be substantiated and connected to the employment-related injury

or disease. However, fee schedules do apply to many charges and balances from fee reductions cannot be collected from the employee. Payment will be made for first aid, medical treatment, hospitalization, physician's fees, drugs, appliances, or other supplies directed for use by a qualified physician. Bills must be submitted within 1 year of the date of service, 1 year beyond the calendar year in which the expense was incurred, or 1 year beyond the calendar year in which the claim was accepted, whichever is later, or they will not be paid. The employee may elect to be treated by a government physician (if available) or by a duly qualified physician of his or her choice who is not excluded. Although payment for preventative treatment is generally not provided, payment may be made for certain specified conditions even though such treatment is designed, in part, to prevent further injury. The specific conditions when payment may be made include: complications of preventative measures which are provided or sponsored by the agency, such as an adverse reaction to a prophylactic immunization; actual or probable exposure to a known contaminant due to an injury, thereby requiring disease specific measures against infection such as tetanus antitoxin or booster toxoid injections for puncture wounds; conversion of tuberculin reaction from negative to positive following exposure to tuberculosis in the performance of duty; and where injury to one eye has resulted in loss of vision, periodic examination of the uninjured eye to detect possible sympathetic involvement of the uninjured eye at an early stage. There shall be no charge for occupational health or OWCP care for DoD employees treated at Federal government medical facilities. However, DoD Components shall continue to bill, at the interagency rate, for OWCP care provided to non-DoD employees by a DoD medical treatment facility. The interagency rate charge shall be processed through the OWCP Revolving Fund.

(2) COP. An employee who sustains a disabling, job-related traumatic injury is entitled, under certain circumstances, to COP for a period not to exceed 45 calendar days pending OWCP's determination of the employee's claim for compensation under FECA. To qualify for COP, the traumatically injured employee or someone authorized to act on his or her behalf must file written notice of injury on a Form CA-1, "Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," within 30 calendar days after the date of injury. COP is not compensation for FECA purposes and is subject to all applicable taxes and payroll deductions. The injured employee or someone authorized to act on his or her behalf must provide written medical evidence to support the disability within 10 calendar days of submitting the CA-1. COP is not applicable for occupational illnesses and diseases claims. The employee must make a separate claim for monetary compensation on a Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," with Form CA-20, "Attending Physician's Report," if the disability exceeds 45 calendar days or results in any permanent disability.

(3) Disability Compensation. Employees may be eligible for one or more of several types of wage loss compensation. Disability benefits are classified based on the nature and extent of disability incurred and are categorized as temporary total, temporary partial, permanent total, or permanent partial.

(a) Compensation Rates. Generally, in cases of total disability, an employee is entitled to compensation equivalent to two-thirds of the weekly salary if there are no dependents, or three-fourths of the salary if there are one or more dependents (see Glossary for definition of dependents). Compensation is tax free. In establishing a person's wage rate, the law recognizes certain additional amounts that may be included in salary, such as premium pay, night and Sunday differential, holiday pay, hazard pay, dirty work pay, quarters allowances and post

differential for overseas employees. Overtime pay is not included except for administratively uncontrollable work covered under 5 U.S.C. 5545(c)(2) (Reference (a)). Under Reference (a) the maximum compensation rate may not exceed more than 75 percent of the monthly pay of the maximum rate of basic pay for GS-15 (excluding locality pay).

(b) Duration of Compensation. Compensation payments for total disability may continue as long as the disability continues and suitable modified work is not available; in some instances, for the lifetime of the employee. As with medical care, there is no total dollar maximum or time limitation.

(c) Loss of Wage-Earning Capability (LWEC). When an injured person suffers a wage loss because of disability that is less than total, compensation may be paid for this partial loss of wages or wage-earning capacity. Provisions of Reference (a) govern the determination of wage-earning capacity. When a claimant has completed 60 days of employment in a suitably modified, formally classified position, the agency should complete a LWEC worksheet and request that a formal LWEC rating be issued. If the position carries a pay rate less than that of the date of injury, compensation will be payable for a loss of wage earning capacity. Such a formal rating can be changed only under very limited circumstances.

(d) Schedule Awards. Reference (a) also provides for payment of compensation for permanent loss or loss of use (either partial or total) of certain internal and external organs; members or functions of the body such as arms, legs, hands, feet, fingers, toes, eyes; or loss of hearing or loss of vision. Each extremity or function has been rated for a specific number of weeks of compensation that can be paid in addition to full salary. If a serious disfigurement of the head, face, or neck results from a job-related injury, an award may also be made for such disfigurement, not to exceed $3,500. Multiple schedule awards may be paid concurrently for different body parts or paid concurrently with the Office of Personnel Management (OPM) retirement benefits. Employees can receive schedule award payments concurrently while receiving severance pay for involuntary separation from their employment. Schedule awards can be paid even if the employee returns to work. However, employees cannot receive wage loss compensation and schedule award benefits concurrently for the same injury.

(e) Vocational Rehabilitation. If the injured employee suffers a vocational handicap due to the injury and cannot resume usual employment, OWCP-directed vocational rehabilitation may be arranged to assist in training for work that the employee can do. The cost for rehabilitation is paid from the Employees' Compensation Fund and charged back to the DoD Component. Rehabilitation service is supervised by OWCP, but is usually provided in cooperation with state and private rehabilitation agencies. In addition to the cost of rehabilitation, an employee may qualify for a monthly allowance of up to $200 necessary for his or her personal maintenance. Employees are also entitled to collect total disability payments during their rehabilitation period. When the rehabilitation program is completed, the claimant is expected to actively seek employment. Vocational rehabilitation is not confined to formal retraining. It includes the employment efforts of vocational rehabilitation counselors and compensation specialists. An offer of a position (employment or reemployment) for which an injured employee is medically qualified is usually the more expedient and less costly method of rehabilitation.

(f) Death Benefits. If the employee's death was due to the job-related injury, dependents are entitled to benefits.

1. Widow or Widower and No Eligible Child. The widow or widower is eligible for 50 percent of the deceased employee's regular pay.

2. Widow or Widower with Eligible Children. The widow or widower is eligible for 45 percent of the deceased employee's regular pay, plus an additional 15 percent for each child, to a maximum not to exceed 75 percent of the deceased employee's regular pay.

3. Eligible Children and No Widow or Widower. An orphaned child is eligible for 40 percent of the deceased employee's regular pay, plus 15 percent for each additional orphan, not to exceed 75 percent of the deceased employee's regular pay. Benefits are divided among the children, share and share alike.

4. Surviving Legal Dependents. If a deceased employee leaves no widow, widower, or child, benefits are paid to the surviving legal dependents of this employee as specified in Reference (a).

5. Remarriage or Death. Widows and widowers receive benefits until death, or remarriage, if they are under age 55. If a widow or widower under age 55 remarries, a lump-sum payment equal to 24 times the monthly compensation he or she is receiving at the time of remarriage is made. If the widow or widower is age 55 or older, compensation continues as long as he or she lives, regardless of remarriage.

6. Orphaned Children. Orphaned children receive benefits until they die, marry, or reach the age of 18. If a surviving child pursues higher education on a full-time basis (generally 12 semester hours), payments will continue until he or she has completed 4 years of study beyond the high school level or until he or she is 23 years of age. Payment will not extend beyond the semester or enrollment period in which the surviving child reaches 23 or completes his or her fourth year of higher education, whichever occurs first.

7. Funeral Expenses. Up to $800 is paid for a deceased employee's funeral expenses. If the employee dies away from home, the cost of transporting the body to the place of burial will be paid in full. Also, an additional sum of $200 is paid to the personal representative of the decedent for reimbursement of the expense of terminating the deceased employee's Federal employment status

8. Death Gratuity Payment. Reference (f) authorizes a death gratuity payment when a civilian employee dies from a traumatic injury sustained in the line of duty on or after August 2, 1990 (November 8, 1996, "Death Gratuity Payment" memorandum, (Reference (g)). This gratuity is payable by the DoD Component, and is payable only when OWCP has approved the death claim. The $10,000 death gratuity (Reference (f)) is payable minus the $200 payable under Reference (a) and the $800 payable under Reference (a) by OWCP.

h. Third-Party Liability. When the circumstances of the employment-related injury or illness create a legal liability on a third party other than an employee or activity of the Federal Government, the government has a subrogation interest (that is, the right to recover any payment it makes should the claimant collect money from another source). The injured employee or survivor is required by Reference (a) to pursue such recovery or assign the right to recover to OWCP. Failure to do so can result in a loss of all benefits.

i. Hearings and Appeals. If an employee (or an employee's survivors) disagree with a final determination of the OWCP, either may request a reconsideration or review. The employee or survivor has the right to a hearing before the OWCP. Further, he or she has the right to appeal any decision to the Employees' Compensation Appeals Board (ECAB), a separate entity in the DOL. The time limits for filing such requests for hearings or appeals vary, and are strictly enforced.

j. Exclusiveness of Remedy. Except for third party rights, FECA is the sole legal avenue by which a Federal employee (or survivors) may recover damages due to an injury or death that is causally related to Federal employment, as noted in Reference (a). FECA is the exclusive remedy; therefore, employees may not sue the U.S. Government for damages on their own.

k. Penalties for Employees and Supervisors

(1) An employee who knowingly makes or knowingly certifies to any false statement, misrepresentation, concealment of fact, or any other act of fraud with respect to a claim under FECA, or who knowingly accepts compensation to which that person is not entitled, is subject to criminal prosecution and may, under appropriate U.S. Criminal Code (18 U.S.C. 287 and 1001 (Reference (h)), be punished by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both.

(2) Any employee, beneficiary, official superior, representative, or other person who, with respect to a claim under FECA, enters into any agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain the payment or allowance of any false, fictitious or fraudulent claim is subject to criminal prosecution and may, under appropriate U.S. Criminal Code provisions (Reference (h)), be punished by a fine of not more than $10,000 or imprisonment for not more than 10 years, or both.

(3) Any beneficiary who pleads guilty to or is found guilty on Federal or State criminal charges of defrauding the Federal Government in connection with a claim for benefits will have his or her benefits terminated effective the date the guilty plea is accepted or a verdict of guilty is returned after trial, for any injury occurring on or before the date of such plea or verdict.

(4) Any beneficiary who is incarcerated in a State or Federal jail, prison, penal institution, or other correctional facility due to a State or Federal felony conviction forfeits all right to compensation during the period of incarceration, and right to benefits is not restored after such incarceration ends, although payment of compensation benefits may resume. Eligible dependents will receive compensation at a reduced rate during the period of incarceration, according to the percentages laid out in Reference (a).

(5) Any claimant convicted of fraud related to FECA claims on or after October 1993 will lose entitlement to FECA benefits under Reference (a).

(6) Any claimant convicted of a felony and imprisoned as a result to claims under FECA will have benefits suspended effective date of imprisonment in accordance with Reference (a).

(7) An officer or employee of the Federal Government responsible for making reports (such as an "official superior") who willfully fails, neglects, or refuses to make a report of injury or files a false report may be fined not more than $500, be imprisoned not more than 1 year, or

receive both penalties.

(8) A partially disabled employee who refuses to seek suitable work or refuses to accept work after it is offered is not entitled to any compensation except for medical benefits.

(9) If an employee refuses to submit to or obstructs an examination by a Federal medical officer or by a qualified private physician as required by OWCP, the employee's right to compensation under FECA will be suspended until the refusal or obstruction ceases. The action of the employee's representative is considered to be the action of the employee for the purposes of this section. The period of refusal or obstruction will be deducted from the period for which compensation is payable to the employee.

(10) An individual who, without good cause, fails to undergo vocational rehabilitation, when directed by DOL, may have his or her compensation reduced.

(11) An employee who fails to make an affidavit about his or her employment (including unremunerated work performed in furtherance of a business) when required, or knowingly omits or understates any part of his or her earnings, forfeits his or her right to compensation with respect to any period for which the affidavit or report was required. Compensation forfeited, under Reference (a), if already paid, will be recovered by a deduction from additional compensation payable, if any, or otherwise recovered under Reference (a) unless recovery is waived.

(12) An employee who refuses to assign or prosecute an action in his or her own name against a third party when required is not entitled to compensation.

2. CLAIMS AND RECORD MANAGEMENT

a. Handling and Controlling Claims

(1) General Information. For proper injury case management, it is essential to closely monitor the completion and control of claims and establish an administrative system that accurately reflects the status of all claims at all times.

(a) The supervisor notifies the ICPA/CPO/HRO immediately or as soon as possible after an injury has been reported.

(b) The supervisor works with the employee to file the claim form through the EDI application, which forwards all claim forms to the ICPA on completion. The ICPA is responsible for processing all injury or occupational illness or disease forms and submitting the claim form to the appropriate OWCP district office in the most expeditious manner.

(c) Injury compensation personnel properly monitor claims to ensure that employees' rights are protected, that appropriate management options are timely exercised, and that workers' compensation costs are effectively controlled.

(2) Advising Employees of Program Benefits. The DOL provides publications for agencies to use in telling their employees about the compensation program and how they may obtain benefits.

(a) The pamphlet, CA-11, "When Injured at Work," is issued by the DOL and provides facts about compensation for civilian employees of the Federal Government. The CPO/HRO issues a CA-11 to each employee at the time of appointment (see Figure 5).

(b) When notified that an injury, occupational illness or disease, or a recurrence of a documented injury has occurred, the employee's immediate supervisor should take time to discuss with the employee the nature of the injury, how, when, and where the injury or recurrence occurred and obtain the names and statements of any witnesses. Also, refer to paragraph 11.b of this enclosure, for information about injuries sustained under special circumstances.

(3) Authorizing Medical Examination and Treatment for Traumatic Injuries

(a) If an employee requests medical care, the supervisor should:

1. Advise the employee that he or she has the initial choice of physician;

2. Prepare and issue Form CA-17, "Duty Status Report;" and,

3. Offer to refer the employee to the activity medical services, if available, for examination and recording of the injury in the employee's medical record. Referral to the activity medical services is not mandatory on the employee's part, nor shall it be construed as the initial choice of the attending physician.

(b) The supervisor, or activity medical services, or activity hospital/clinic or ICPA (as required locally):

1. Makes an appointment with the physician of the employee's choice.

2. Informs the employee that he or she should make another choice if the physician is not available or is excluded from payment under FECA.

3. Issues Form CA-16, "Authorization for Examination and/or Treatment," to a physician willing to provide treatment. Informs the employee that a change of physician requires prior OWCP approval or referral by his or her attending physician. The injured employee should receive the Form CA-16 within 4 hours of request. If an employee has reported an injury several days after the fact, or did not request medical treatment within 24 hours, the supervisor may still authorize medical care using form CA-16. The supervisor may, however, refuse to issue a CA-16 if more than a week has passed since the injury on the basis that the need for immediate treatment would normally have become apparent in that period of time;

4. Instructs the employee to contact the supervisor immediately after examination and treatment.

5. Informs the employee that it is the employee's responsibility to provide medical evidence as to his or her duty status and to advise the physician of the fact that light duty is available should the employee be physically able to perform such duty.

(c) The employee should:

1. Advise the supervisor or activity physician of his or her choice of physician (who may be an activity medical officer).

2. Choose a physician who is eligible and willing to give timely examination and treatment, if initial choice of the physician is not available to give examination or is on the excluded list;

3. Inform the physician of the availability of light duty, if the employee has been informed that light duty is available.

4. Notify the supervisor of duty status immediately following treatment and regularly after that.

(4) Filing the Claim

(a) The supervisor will ensure the completeness and, to the extent possible, accuracy of each claim prepared before submitting it to the ICPA.

(b) Immediately on notification that an injury has occurred, the immediate supervisor should investigate the claim. The ICPA/CPO/HRO or safety office should also investigate, if necessary. The investigation should either substantiate the claim or show doubt about the validity of the claim. Some sources and expertise available during the investigation are:

1. Injured employee.

2. Witnesses (or others in the area who heard, saw, or have knowledge).

3. Immediate supervisor.

4. Treating physician.

5. Safety staff.

6. Employee's injury compensation case file(s).

7. Official personnel folder.

8. Activity physician and employee's medical file. If review of the medical records shows evidence to dispute the claim or shows that the injury may have only caused an aggravation of a preexisting condition, such evidence or a memo signed by the activity physician to include the name of doctors and hospitals where the employee was treated is sent to the ICPA for forwarding to OWCP.

(c) Based on the results of the investigation, the supervisor shall decide whether to controvert the claim. If the supervisor is confident that there is no basis for controversion, he or she shall immediately print and submit the claim and all supporting documentation to the ICPA/CPO/HRO for forwarding to OWCP. If the investigation reveals that there are

questionable circumstances surrounding the claim, the supervisor contacts the ICPA.

(d) The ICPA develops a controversion package in accordance with section 5 of this enclosure, "Controversion of Claims," and if possible, forwards it with the claim to the OWCP. The supervisor notifies the employee verbally or in writing that the claim has been controverted. Either a copy of the notice or a memorandum for record should state that the employee was notified of the controversion.

1. If it is decided that either the traumatic injury or occupational disease claim, or any portion of it should be challenged, the ICPA shall enter the reasons in Block 35 of either the CA-1 or CA-2 claim form.

2. If it is decided that the entitlement to all or a portion of COP resulting from a traumatic injury claim should be controverted, the ICPA shall enter the reasons for controversion in Block 36 of the CA-1 claim form.

(e) In either a challenged or controverted case, the ICPA must ensure that any supporting documentation, such as signed witnesses' statements, investigative reports, and photographs, are forwarded to OWCP once a claim number is assigned on the case.

(f) The supervisor shall notify the employee verbally or in writing that the claim has been controverted. Either a copy of the notice or a memorandum for record should state that the employee was notified of the controversion.

b. Completing OWCP Forms

(1) Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation." Use this form for traumatic injury cases only. A traumatic injury is defined as "a wound or other condition of the body caused by external force, including stress or strain." It must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident, or series of events or incidents within a single day or work shift. (See Glossary for definition of traumatic injury.) The Form CA-1 provides official notice to the employee's supervisor and to OWCP that a traumatic injury has occurred. (Figure 6 contains a sample Form CA-1, an information sheet, and instructions for completing the form.)

(a) Time Requirement. The employee should complete and submit the Form CA-1 as soon as possible after the injury, but no later than 30 days after the date of injury. To be eligible for COP, the employee must file the Form CA-1 within 30 days from the date of injury. Statutory time requirements for other FECA benefits will be met if the Form CA-1 is filed no later than 3 years after the injury. Someone acting in the employee's behalf (that is, a co-worker, a relative, or the supervisor) may complete the Form CA-1.

(b) General Procedures

1. The employee's CPO/HRO, supervisor, or activity's medical service provides the employee with a Form CA-1, or provides access to the electronic CA-1 form through the EDI Application.

2. The employee completes items 1 through 15. The CPO/HRO, supervisor, or activity's medical service should complete items 17 through 38 on the Form CA-1, print the completed form, sign the completed form, and request that the employee sign the completed form.

3. If the employee is eligible for COP, but elects annual or sick leave, the supervisor or ICPA explains COP to the employee.

4. The supervisor gives the employee or the employee's representative a signed receipt.

5. The supervisor forwards the Form CA-1 to the ICPA.

(c) Forwarding to the OWCP. The ICPA receives electronic notification of the completed form and reviews the Form CA-1 for accuracy and completeness. The ICPA must code the appropriate items on the form.

1. If the employee has lost time from work or incurred medical expenses, the ICPA prints a hard-copy of the completed form, approves, and submits the electronic form to OWCP within 10 working days from the date of first notice. The ICPA files one copy of the CA-1 in the EMF and one copy in the working folder for this claim. The ICPA shall send notification to the agency Safety Officer that an injury has been claimed.

2. If the employee does not lose time from work and has no medical expenses, the ICPA files the original Form CA-1 in the EMF and sends notification to the agency Safety Officer that an injury has been claimed.

3. If the employee later seeks medical treatment, loses time from work, or both, the ICPA will retrieve the claim from the EDI application, correctly recode the claim, print, approve, and then submit Form CA-1 to OWCP.

(2) Form CA-2, "Notice of Occupational Disease and Claim for Compensation." The Form CA-2 provides official notice to an employee's supervisor and OWCP of an occupational illness or disease caused or aggravated by factors of employment. (Figure 7 contains a sample of a completed Form CA-2 and an information sheet. (Instructions for completing the Form CA-2 are at Figure 8). Besides submitting this form, the employee must furnish a narrative statement and supporting documentation - explaining how the ailment is related to the work environment (see section 3 of this enclosure).

(a) Time Requirement. The injured employee or someone acting on his or her behalf should complete and submit the Form CA-2 to the official supervisor. Statutory time requirements will be met if the Form CA-2 is filed no later than 3 years after the date the employee first became aware, or if the employer had prior knowledge of the illness or disease. It should be emphasized that the employee has the responsibility to provide all the necessary documentation as outlined in item 2 under "Instructions for Completing Employee's Portion of the Form CA-2," before submitting it to the official supervisor. Occupational disease cases are not eligible for COP.

(b) General Procedures

1. The employee's supervisor helps the employee in obtaining the Form CA-2 and appropriate checklists.

2. The employee completes items 1 through 18. The CPO/HRO, supervisor, or activity's medical service should complete items 19 through 35 on the Form CA-2; print the completed form, and request that the employee sign the completed form. Someone acting on the employee's behalf; that is, supervisor, coworker, or relative may complete Form CA-2 if the employee is unable to do so.

3. The supervisor gives the employee or the employee's representative a signed receipt.

4. The supervisor submits the Form CA-2 to the ICPA.

(c) Forwarding Form CA-2 to OWCP. On receiving electronic notification of a completed Form CA-2, the ICPA should review all entries for completeness and accuracy of information. The ICPA should ensure that the additional information required by the Form CA-2 instructions and Occupational Disease Checklist is included. If the employee did not submit the required statements and medical reports, the ICPA should emphasize to the employee that failure to do so will either jeopardize the claim or delay OWCP's adjudication process. If the employee insists on submitting the Form CA-2 without supporting documentation, the ICPA should approve and submit the CA-2 to OWCP, noting in Block 35 of the form that the employee was advised to submit supporting documentation.

(3) Form CA-2a, "Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation"

(a) Purpose. Form CA-2a (see Figure 9 for sample form and instructions) reports a recurrence of an earlier disability. An employee is considered to have a recurrence when, after having returned to work, he or she is again disabled and stops work because of the original injury or occupational disease. (A new period of disability is not a recurrence if it is caused by a condition that results from a new incident or injury even to the same portion of the body previously injured, or from a new exposure to the cause of a previously suffered occupational disease.) The ICPA may help the employee and supervisor in filing a recurrence claim.

(b) General Procedure

1. The employee notifies the supervisor of the recurrence.

2. The employee completes Form CA-2a, Part A. If the employee is no longer employed with the Federal Government, the employee should complete Part C.

3. The supervisor completes Part B.

4. The supervisor forwards the Form CA-2a to the ICPA.

5. The ICPA forwards the Form CA-2a (and controversion package, if appropriate) and related documentation to the OWCP.

(4) Form CA-5, "Claim for Compensation by Widow, Widower, and/or Children"

(a) Purpose. Form CA-5 (see Figure 10 for sample form and instructions) serves as official notice to OWCP of surviving widow's, widower's, or children's claim for compensation due to an employee's death, which resulted from job-related injury or illness.

(b) Time Requirement

1. If possible, the ICPA forwards Form CA-5 to OWCP within 30 days of the death, but no later than 3 years after the death.

2. If death resulted from an injury for which a disability claim was timely filed, there is no time restriction on submission of the Form CA-5.

(c) General Procedure

1. The ICPA provides a Form CA-5 (all items on the Form CA-5 are self-explanatory).

2. The widow, widower, child or children, or child's or children's guardian completes the Form CA-5.

3. If death resulted from an injury or illness previously reported to OWCP, the ICPA enters the OWCP file number on the upper right corner of the Form CA-5.

4. The ICPA obtains a certified copy of the death certificate and a copy of the autopsy report (if available) to forward to OWCP.

(5) Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren"

(a) Purpose. Form CA-5b (see Figure 11 for form and instructions) serves as official notice of eligible dependent's (parents, brothers, sisters, grandparents, or grandchildren) claim for compensation due to employee's death, which resulted from job-related injury or illness.

(b) Time Requirement. Claim must be filed within 3 years following date of death.

(c) General Procedure

1. The ICPA provides a separate Form CA-5b to each claimant.

2. Each claimant completes a Form CA-5b (instructions are on the back of the form) and returns it to the ICPA.

3. If death resulted from an injury or illness previously reported to OWCP, the ICPA enters the OWCP file number on the upper right corner of Form CA-5b. A separate form is required for each person claiming benefits.

(6) Form CA-6, "Official Superior's Report of Employee's Death"

(a) Purpose. Form CA-6 (see Figure 12 for sample form and instructions) serves as official notice of an employee's job-related death.

(b) General Procedure

1. In case of an employee's job-related death, the supervisor must immediately notify the ICPA and the Safety Office. The ICPA, in turn, will immediately notify OWCP and the supporting DoD liaison by telephone, priority message, or facsimile message. Expedience is required so that the OWCP medical advisor can advise if an autopsy will be required.

2. In all death cases, the ICPA will help supervisors in completing the Form CA-6.

3. After a thorough investigation by the Safety Office of the circumstances surrounding the death, the supervisor completes the Form CA-6 and returns it to the ICPA.

4. If death resulted from an injury or illness previously reported to OWCP, the ICPA enters the OWCP file number in the upper right corner of the Form CA-6.

5. The ICPA reviews the form for completeness and submits it to OWCP immediately. (Any missing information should be obtained in the quickest way possible.)

(7) Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease, with Attached Form CA-20, Attending Physician's Report"

(a) Purpose

1. Form CA-7 (see Figures 13, 14, 15, and 16 for sample forms and instructions) is used to claim compensation for wages or time lost due to a traumatic injury or occupational disease. OWCP must have Form CA-1 or CA-2 on file to process the Form CA-7. If Form CA-1 or CA-2 was not previously submitted, it should accompany the Form CA-7 to OWCP.

2. Form CA-7 is also used to initiate a claim for a schedule award or leave buy-back.

(b) General Procedure

1. The ICPA provides the employee with a Form CA-7 with attached Form CA-20, "Attending Physician's Report." In traumatic cases, if the medical evidence shows that disability will extend past the COP period, the ICPA provides a Form CA-7 to the employee with instructions to return it to the supervisor or to the ICPA 10 days before COP expires. The ICPA

should send Form CA-7 to OWCP by the 40th day of COP to avoid interruption of the employee's pay. In occupational disease cases, the supervisor should forward Form CA-7 to the ICPA within 10 calendar days from the date pay stops. The ICPA should forward to OWCP as soon as possible, but no later than 5 workdays after its receipt from the employee. When filing Form CA-7 for continuing periods of disability, the claimant should complete the form at 2-week intervals until he or she returns to full-time duty or OWCP places him or her on the periodic rolls. The ICPA should send the Form CA-7 to OWCP as soon as possible, but no more than 5 working days after receipt from the employee.

2. The employee or someone acting on the employee's behalf completes Part A (items 1 through 20) of the form.

3. The supervisor completes Part B (items 20 through 38).

4. The employee takes the Form CA-20 to the attending physician and requests the completed form be returned to the ICPA.

5. The ICPA reviews the Form CA-7 for completeness and accuracy and sends it to OWCP with the following attachments: a copy of the position description for the job held on the date of injury and a copy of the SF 50, "Notification of Personnel Action," in effect on the date of injury; physical requirements (SF 78, "Certificate of Medical Examination"), for the job held on the date of injury; a copy of most recent "Application for Federal Employment," from the Official Personnel File (OPF) (the Form CA-7 should be promptly forwarded to OWCP even if the attachments have to be sent later).

6. The ICPA makes periodic follow-ups with OWCP until a decision has been rendered.

(8) Form CA-16, "Authorization for Examination, and/or Treatment"

(a) Purpose. Form CA-16 (form contains instructions) is used to authorize an employee who claims a traumatic injury to obtain examination or treatment at a medical source of his or her choice. Such a medical source may be: any duly qualified local physician, surgeon, osteopath, and, within the scope of their specialty, a podiatrist, dentist, clinical psychologist, optometrist, and (within certain limitations) a chiropractor. Form CA-16 will not be issued to providers who are excluded or suspended from participation in the FECA program. An excluded physician may be reimbursed only for services rendered in a medical emergency. In emergencies, the employee will be sent to the nearest available physician or hospital. The physician who provides the emergency treatment is not usually considered the employee's initial choice of physician. In emergency cases, it is not necessary to take time to fill out the appropriate forms; however, these forms must be submitted within 48 hours following first examination or treatment. Form CA-16 should never be issued without a specific medical provider indicated; without the date of issue and signature of the activity representative entered; or, once the urgent need for immediate treatment has passed.

(b) OWCP Approval. Form CA-16 is issued in traumatic cases only. Issuance of a Form CA-16 can obligate the Department of Defense for the cost of medical treatment for a 60-day period from the date of issuance. If there is doubt that the injury is job-related, block 6.B.2. should be checked. Only one CA-16 should be issued for an injury. It may not be issued for an occupational claim (Form CA-2) without prior approval from OWCP. Form CA-16 should rarely be issued in cases of recurrence. It may not be issued if more than 6 months has elapsed since the employee last returned to work. Form CA-16 is not used to authorize a change of physician after the initial choice is exercised by the employee. Form CA-16 should not be used to authorize medical testing for an employee who has merely been exposed to a workplace hazard, unless the employee has sustained an identifiable injury or medical condition as a result of that exposure.

(c) General Procedure. The supervisor or the activity medical facility completes Part A (items 1 through 13) and gives the original to the employee. The employee should receive Form CA-16 within 4 hours of request. "Light Duty is Available" may be shown on the Form CA-16 provided to the physician or by a letter attached to the Form CA-16 informing the physician of light duty (see Figure 17). Physicians must be informed of possible accommodations provided for injured employees.

1. The employee gives the original to the physician or treating medical facility.

2. The attending physician completes Part B (items 14 through 38) of the Form CA-16.

3. On receiving the completed original Form CA-16 from the attending physician, the ICPA forwards it to OWCP.

(9) Form CA-17, "Duty Status Report"

(a) Purpose. Form CA-17 (see Figure 18 for sample form and instructions) is used in disabling injury cases to provide the supervisor and OWCP with a brief interim medical statement concerning the employee's ability to return to full or light duty (Figures 19, 20, and 21 contain sample letters that can be used to transmit the Form CA-17 to the treating physician).

(b) General Procedure

1. The issuing official completes Part A, items 1 through 7.

2. The employee gives the Form CA-17 to the attending physician.

3. The attending physician completes Part B of the Form CA-17 (items 8 through 20).

4. If the physician completes the Form CA-17 immediately, the employee may return it to the supervisor. "Light duty is available" may be entered on the Form CA-17.

5. Upon receipt of the Form CA-17 from the attending physician, the supervisor or activity physician determines whether the employee can return to full duty or to a light-duty assignment.

6. The ICPA should forward the original Form CA-17 to OWCP and retain a copy with the compensation case file.

c. Duty Status Determination

(1) General Guidance. The claimant or treating physician should return medical evidence to the supervisor or ICPA immediately after examination or at the start of the employee's next scheduled work shift so the employee's duty status can be decided. Upon determination of status, the employee will be:

(a) Returned to full duty;

(b) Assigned to, or continued in a light duty status;

(c) Placed in a COP status; or,

(d) Placed in a sick leave, annual leave, or leave without pay (LWOP-OWCP) status as elected by the employee.

(2) Light Duty. Light duty is provided to an employee who has sustained a job-related injury and has physical limitations identified by the treating or activity physician. However, the light-duty assignment should be within the limitations imposed by the treating physician. When an employee has partially overcome a compensable disability, it is DoD policy that supervisors make every effort to assign the employee to light duty within his or her medically defined work limitations.

(a) In determining light-duty assignments, the supervisor considers:

1. The employee's medically-defined work limitations;

2. The employee's job skills;

3. The work organization to which the employee is regularly assigned; and,

4. The hours that the employee regularly works.

(b) Supervisors may verbally make light-duty offers, but should follow up in writing within 2 business days of the verbal job offer. Copies of the job offer should be sent or faxed to the treating physician. The offer should include a description of the duties to be performed, the specific physical requirements of the position and any special demands of the workload or unusual working conditions, the organizational and geographical location of the job, the date on which the job will first be available, the date by which a response to the job offer is required, and

pay rate information for the offered job. The employer should send a complete copy of any job offer to OWCP when it is sent to the employee.

(3) LWOP Documentation. The supervisor is responsible for submitting an SF-52, "Request for Personnel Action," when an employee is on LWOP for 80 continuous hours or more and is expected to receive compensation benefits. The Nature of Action code should be entered as 460 (LWOP/OWCP), and the authority code must read Q3K. The remarks section should read, "The employee is expected to be paid under 5 U.S.C. 81." If DOL subsequently denies the claim, the authority code must then be corrected to reflect LWOP only and the authority code must read DAM rather than Q3K. The supervisor, on the employee's return to duty (RTD), should immediately notify both OWCP and the ICPA, and should submit an RTD Form SF-52 to the ICPA. The RTD SF-52 should be reviewed by the ICPA and submitted immediately along with a cover letter verifying the employee's RTD to OWCP to ensure that compensation has been terminated (OPM "Guide to Processing Personnel Actions," (Reference (l)).

(4) Obtaining the Status of the Claim. The ICPA obtains information from OWCP, such as current medical information, Work Capacity Evaluation Form (OWCP-5), and rehabilitation information by telephone or written request.

d. Injury Compensation Records

(1) Access and Disclosure Guidelines. All records related to an employee's injury or illness are sensitive. The ICPA should protect them from unauthorized access and disclosure; limit access to these records to those individuals with an authorized need to know; use caution when releasing medical reports; and under no circumstance, release a psychiatric report. If in doubt, the ICPA should contact OWCP or the supporting DoD liaison for guidance. It is mandatory that the employee specify in writing the name of the individual designated to act as his or her representative.

(2) Injury Compensation Case Files. The ICPA prepares and maintains an injury compensation case file for each injury or illness for which compensation is claimed. As a minimum, the case file is to consist of copies of OWCP forms, relevant medical information supplied by physicians, claim-related correspondence, and other sensitive information that specifically relates to the injury or illness. Case files should be secured in locked cabinets or otherwise secured as required by the Privacy Act. All records are official records of OWCP and are covered by the government wide Privacy Act system of records titled DOL/GOVT-1.

(a) Claim Numbers. Upon electronic notification from CPMS that OWCP acknowledges receipt of the claim and assigns the claim number, the ICPA shall verify ownership of the case and chargeback code and, if there are discrepancies, the ICPA shall notify OWCP district office immediately. The ICPA shall also annotate all appropriate documents with the claim number in the upper right-hand portion of the document before forwarding to OWCP.

(b) File Setup. The ICPA shall:

1. Upon receipt of a Form CA-1 or Form CA-2 requiring submission to OWCP, prepare a working folder.

2. Make sure labels have the minimum information: name; Social Security number; date of injury; and OWCP claim number (when received).

3. Arrange documents chronologically, from bottom to top, with a copy of the claim form (CA-1 or CA-2) on the bottom. Ensure all memos, notes, and records of telephone calls contained in the case file are dated and signed.

4. Arrange file folders alphabetically.

5. Maintain a separate folder for each injury or illness.

6. File recurrences (Form CA-2a) with the original injury file folder.

7. If an employee is transferred to a different agency or servicing CPO/HRO, forward his or her file folder to the new servicing activity. (A skeleton file may be retained at the losing CPO/HRO, if desired.)

8. Maintain two separate sets of files: one for active compensation cases and one for inactive cases.

9. Retain the injury file folders as follows:

a. No Lost Time/No Medical Expense. Ninety days after the claim was submitted, retain the CA form as an inactive file at the agency or an agency document storage facility.

b. First Aid. One year after the date of the last medical appointment or treatment, retain the CA form and medical reports as an inactive file at the agency or an agency document storage facility.

c. Medical Expenses Only. Two years after the date of the last appointment or medical treatment, retain the CA form (including employee, supervisor, and witness statements), claim acceptance/denial letter, any appeal decisions, claims for recurrence, decisions on claims for recurrence, and the most recent medical report contained in the file detailing the claimant's ability to work. Keep these documents as an inactive file at the agency or an agency document storage facility. Purge all other non-pertinent documents such as transmittal letters and bills from the file.

d. Medical Expenses and COP. Two years after the date of the last appointment or treatment retain the CA form (including employee, supervisor, and witness statements), claim acceptance/denial letter, any appeal decisions, claims for recurrence, decision

on claims for recurrence and the most recent medical report contained in the file detailing the claimant's ability to work. Keep these documents as an inactive file at the agency or an agency document storage facility. Purge all other non-pertinent documents such as transmittal letters and bills from the file.

e. Medical Expenses, COP and Compensation. Four years after the latter of the last medical appointment or treatment, termination of compensation, or expiration of appeal deadlines retain the CA form (including employee, supervisor, and witness statements), claim acceptance/denial letter, any appeal decisions, initial CA-7 submitted to OWCP, claims for recurrence, decision on claims for recurrence, awards of compensation for impairment, and the most recent medical report contained in the file detailing the claimant's ability to work. Keep these documents as an inactive file at the agency or an agency document storage facility. Purge all other non-pertinent documents such as transmittal letters and bills from the file.

10. All active and inactive records are governed under the disclosure provisions of DOL/GOVT-1, Office of Workers Compensation Programs, Federal Employees' Compensation Act File.

(3) Defense Injury/Unemployment Compensation System (DIUCS). The Defense Injury and Unemployment Compensation System (DIUCS) and its related components are the foundation of the standard enterprise-wide civilian HR system for injury compensation program management. DIUCS is a valuable Web-enabled tool designed to provide comprehensive, detailed information; a more efficient method of filing initial injury claims; and a more efficient method of record keeping, thus providing more time for the ICPA to manage his or her program effectively. DIUCS contains:

(a) Individual Case Records. The DIUCS provides secure, detailed information about individual workers' compensation claims. Data is immediately available to answer queries about personnel matters, salary information at time of injury, OWCP information such as claim number, status, latest medical bill payments or compensation disbursement information.

(b) Electronic Data Interchange (EDI). EDI enables DoD Components to file workers' compensation claims securely through electronic transmission with OWCP. The EDI provides Web-enabled CA-1 and CA-2 claim forms that are accessible to supervisors and employees for completion and forwarding to the local ICPA. Electronic notification alerts the ICPA to a claim requiring processing. Through a secure link, the ICPA may review, code, and transmit a claim to OWCP. Within 48 hours, EDI electronically notifies the ICPA of a claim number assignment at the OWCP district office.

(c) Reports. In addition to pre-constructed or "canned" reports, the ICPA can use the DIUCS report function to design and create a master log or unique activity reports. Log and reports should begin and end with the DOL billing year (July 1 through June 30). If the DIUCS is not available, the ICPA must maintain a master record by manual methods or any other reliable data system.

e. Program Management Tools. The Defense Portal Analysis Center (DefPAC) is the enterprise-wide injury compensation reporting system that provides a virtual library of workers' compensation information, as well as an aggregate, corporate-level data reporting tool for workers' compensation statistics. DefPAC is a secure, Web-enabled system that provides one-

stop access to all references, system applications, training modules, and statistical data reports necessary to understand the workers' compensation program and is accessible by all organizational levels in each DoD Component.

(4) (Added)(DAF) Once a claim is accepted by the DOL's OWCP, the relevant district office maintains the official claim file. All records maintained by the OWCP are official records and protected by the Privacy Act of 1974. (T-0). AFPC/ICO shall establish, maintain, and protect working claim files in accordance with paragraph 2(d) 1-2 of Enclosure 3. The assigned ICS may maintain claim documents in separate working files and use and release such material consistent with the reason for which the material was collected and as permitted by the Privacy Act of 1974. Any IC claim file maintained by AFPC/ICO and the assigned ICS is considered an alternate location for the records, and remain under the jurisdiction of the OWCP. A notice of injury filed in ECOMP to the AFPC/ICO but not filed with OWCP (claims that were filed as first aid or no lost time and no medical expense) are retained in hard copy with all original Forms CA-1s/CA-2s indefinitely. If there has been no expenses involved with a claim for more than two years, the ICS shall send a letter to OWCP requesting closure. (T-3).

(5) (Added)(DAF) Each assigned ICS shall ensure the DAF codes on its claims of injury, disease and death are correct when entered into the OWCP data processing system and as they appear on the DOL's quarterly chargeback report. (T-3). Ensuring code accuracy at these two stages helps reduce errors in the chargeback system.

(6) (Added)(DAF) To further prevent incorrect entries from appearing on the DOL's quarterly chargeback report and annual bill, AFPC/ICO shall also provide a copy of the report to each Civilian Personnel Section (CPS). (T-3). The CPS will report any identified errors to the AFPC/ICO within 90 days of the report's receipt. (T-3). AFPC/ICO, in turn, will confirm any identified errors and, with appropriate documentation, request corrections through the Department of Defense Liaison.

(7) (Added)(DAF) If another agency or component transfers a case to the DAF, the cost of compensation benefits and other expenses paid on behalf of the employee shall be included in the costs attributed to DAF in accordance with Title 5 United States Code 8147. (T-0).

3. OCCUPATIONAL ILLNESS OR DISEASE CLAIMS AND REQUIRED AGENCY DOCUMENTATION

a. General Information on Documentation

(1) Purpose of Documentation

(a) Provide compensation personnel with a general knowledge of complexities involved and the importance of obtaining and submitting required documentation to support or controvert an employee's claim.

(b) Ensure that the ICPA involves all appropriate functions in submitting proper activity documentation, whether it supports or contradicts the employee's allegations.

(2) Activity Responsibility. Occupational illness or disease cases require special effort and extensive documentation. ICPA's should use all resources available in acquiring information. Normally, this will include medical records and opinions, co-worker statements, information obtained from the official personnel folder and activity medical records, documentation from the occupational health and safety officers, and information regarding the feasibility and availability of alternate employment.

(a) It is important that the ICPA ensures that the evidence submitted in occupational illness or disease cases is clear, concise, and factual, and includes all required documentation. As appropriate, the supervisor, occupational health official, audiologist, safety and medical officers, and other interested parties submit their respective portions of the documentation to the ICPA for review and forwarding to OWCP.

(b) The ICPA should review all evidence before submitting it to OWCP, taking whatever actions are necessary to clarify contradictory or vague statements and obtain additional information. In unusual cases, this process may require requesting assistance from the CPO/HRO to resolve questionable issues. In some cases, it may be beneficial to coordinate the cover letter to OWCP with the functional offices involved.

b. Categories of Illnesses

(1) Hearing Loss (Types, Causes, Prevention). Supervisors and compensation personnel should have some basic knowledge of the possible causes of hearing loss and be extremely conscientious in ensuring that documentation is complete and factual. (See Figures 22, "Hearing Loss Checklist" and 23 for sample hearing loss case. Also refer to Figure 24 for sample supervisor's/employee's questionnaires and Figure 25 for sample work history and occupational noise exposure form.) Types of hearing loss fall into several categories.

(a) Sensorineural hearing loss generally occurs in the inner ear and can be caused by exposure to hazardous noise levels. The latter may consist of intermittent or continuous exposure to steady state, impulse noise, or both. In most cases, however, noise-induced hearing loss will not occur if proper hearing protection devices are well-fitted and used when an employee is exposed to hazardous noise levels. Sensorineural noise-induced hearing loss is permanent. Neither medicine nor surgery can reverse this condition. Unprotected exposure to hazardous noise levels of 85 dBA for 8 hours per day may cause permanent decrease in the auditory threshold of hearing sensitivity. A significant auditory threshold shift is defined as a decrease of 20 dB or more at any test frequency for either ear. This type of hearing loss generally occurs in the high frequencies particularly at 4000 Hz. A noise-induced hearing loss will result in the employee's inability to understand speech. In severe cases, a hearing aid may be of some benefit.

1. Hazardous noise is defined as: (1) exposure equal to more than 85 decibels when measured on the dBA scale for 8 hours in a 24-hour period or its equivalent exposure at higher levels for shorter times, or (2) impulse or impact noise that is more than a peak sound pressure of 140 dB. Noise-induced hearing damage primarily depends on the intensity and duration of the noise. As sound intensity goes up, duration of exposure must go down. A few individuals are more susceptible to hearing damage than the normal population; therefore, noise-induced loss can be identified only through routine audio-metric monitoring.

2. Not all exposure to hazardous noise is produced at the worksite, nor is it limited to employment. For example, loud noises, such as those produced by chainsaws, snowmobiles, motor boats, motorcycles, firearms, lawnmowers, home carpentry equipment (saws, drills, or other), and automotive equipment can also cause or contribute to noise-induced hearing loss.

3. Many hearing loss claims filed by employees do reveal some exposure to noise levels well above 85 dBA. In these cases, the duration of the exposure determines the probability of impairment. For instance, exposure to a dynamometer (105 dBA) used in a vehicle maintenance shop for about 45 minutes per week should not cause a noise-induced hearing loss, even without the use of hearing protectors (muffs or plugs). Normally, employees assigned to a hazardous noise area are not constantly subjected to hazardous noise. The flight line, for example, is designated a hazardous noise area, but actual exposure depends on aircraft activity and support equipment in use. Also, a carpentry shop designated as a noise hazardous area may simply mean that equipment there can produce hazardous noise. If equipment is not in operation, there is obviously no exposure to hazardous noise.

4. Noise-induced hearing loss can be prevented by proper use of hearing protection. No occupations involving hazardous noise exposure have been identified for which there was no adequate protection or method for preventing personnel from being over exposed 29 CFR 1910.95 (Reference (m)), Occupational Safety and Health Administration, Labor, mandates that protection against the effects of noise exposure should be provided when the sound levels exceed those shown below for the period of time identified.

Table. Permissible Noise Exposure as of July 1, 2003

Duration per day (in hours)	Sound level dBA Slow response
8	90
6	92
4	95
3	97
2	100
1.5	102
1	105
0.5	110
0.25 or less	115

(b) Conductive hearing loss occurs in the outer or middle ear, or both, and can be caused by ear infection, sudden pressure changes, or blows to the head. Generally, conductive hearing loss is characterized by a perforated eardrum, fluid in the middle ear, or damage to the ossicles (middle ear bones), which would prevent sound from reaching the inner ear (cochlea). In most cases, this type of hearing loss is not occupationally related and can usually be corrected by medical and surgical methods. When not medically contraindicated, the use of amplification can be of significant benefit.

(c) Non-organic behavior (exaggerated hearing loss), malingering (willful falsification of test results), or feigning may occur when an individual expects to gain financially from a hearing loss; expects other desired action such as being retained on an assignment; or desires reassignment to avoid unpleasant duty. Non-organic behavior is first suspected when the perceived hearing ability appears better than the audiometric test results indicate. Frequently invalid, unreliable, and inconsistent test results are obtained. Often the patient will display exaggerated attempts at lip reading and over-dramatization of his or her hearing difficulty. Advanced auditory tests, which do not require a voluntary patient response, are available for the audiologist to determine whether the test results are accurate, if a hearing loss is present, and the type and extent of disability.

(2) Communicable Diseases. Communicable disease claims include those for infectious or contagious diseases caused by microorganisms or by parasites contracted from another person, a contaminated article, or insect or animal.

(3) Dermatitis or Skin Diseases. Normally, dermatitis claims concern inflammations of the skin resulting from contact with substances of an irritant nature from such chemicals as dye, ink, solvent, detergent, or from plants (poison ivy, poison oak). (Checklist for skin disease claims is at Figure 26.

(4) Silicosis, Asbestosis, and Chronic Bronchitis. Silicosis is caused by inhalation of particles of dust or stone, sand or flint containing silica (silicon dioxide). The mere inhalation of dust alone will not cause silicosis; the dust must contain silica. Asbestosis is caused by inhalation of asbestos particles or fibers. In these cases, it is essential that substantial exposure in the Federal employment be well established and the silica content of the dust be provided. Chronic bronchitis is a common condition that may be caused by exposure to chemical irritants, smoke or fumes, repeated attacks of acute bronchitis or bronchial asthma, prolonged inhalation of irritating vapors, dust or smoking tobacco. (See checklist in Figures 27 for required documentation: CA-35C and CA-35F.)

(5) Cardiovascular Diseases. There are several types of cardiovascular diseases, and claims may be made for any of them. Even in situations where the condition was clearly not caused by work, it may be alleged that factors of employment aggravated a condition or precipitated a period of disability. (See Figure 28 for coronary/vascular condition checklist.) Some types of cardiovascular problems are:

(a) Congestive Heart Failure. A general circulatory problem that occurs when the heart is unable to put out enough blood to meet the requirements of the body.

(b) Arteriosclerotic Heart Disease (ASHD). Hardening and narrowing of the coronary arteries resulting in the heart not receiving the oxygen it needs. Characteristically, this is a degenerative change that occurs in middle or old age. It is more common in men than women.

1. Coronary Insufficiency (Occlusion). A mild form of ASHD, also known as angina pectoris. The condition occurs due to an inadequate supply of blood and oxygen to the heart. These episodes are often precipitated by physical exertion or emotional stress.

2. Myocardial Infarction. The more serious form of ASHD, in which part of the

heart muscle is completely deprived of oxygen and dies.

(c) Rheumatic Heart Disease. Occurs because of rheumatic fever (usually in childhood), which causes damage to the valves of the heart.

(d) Hypertensive Heart Disease. A defect present at birth.

(e) Congenital Heart Disease. A defect present at birth.

(f) It is important for OWCP to be able to distinguish between a chronic underlying coronary artery disease or other heart disease, which may not be attributable to employment.

(6) Psychotic and Neurotic Disorders. Emotional disorders can cause disability; an employee may file a claim based on an emotional disorder if the stress and/or strain are related to the work environment. Normally, the work environment is not the sole cause of an emotional disorder, which usually results from a combination of additional factors including genetic history and home environment. It is especially important for OWCP to receive factual evidence concerning the employee's medical history and work and home environment (CA-35G, Psychiatric Checklist at Figure 29).

(7) Low Back Strain. Most claims for back strains are alleged to have occurred because of traumatic injury rather than because of general working conditions and thus fall under that category rather than an occupational illness. The back is prone to progressive deterioration associated with aging. A back condition may also be due to an injury having no relation to the work, faulty posture, a congenital condition or a disease process. ICPA's should carefully review low back strain claims based on traumatic injury and if the situation warrants, obtain and provide the same information to OWCP as for occupational illness claims.

(8) Radiation and Similar High Energy Injuries. These claims can include, injuries involving X-rays, radioisotopes and radio nuclides, radar, microwaves, radio frequencies, alpha and beta particles, gamma rays, high energy neutrons, and laser beams. These claims are handled by District 09.

(9) Other Occupational Illness or Disease. The activity obtains and reviews all pertinent documentation, including the evidence required in Figures 30 and 31, and forwards to OWCP (CA-35H and CA-35A). In most traumatic injury cases, the documentation required is far less extensive; but, the ICPA should carefully review each claim. When evidence is required from the employing activity for occupational illness and it is relevant to a traumatic injury claim, the ICPA should obtain and forward it to OWCP.

c. Claims Filed by Claimants After Federal Employment Has Been Terminated

(1) Initial Action Required. Often a claim for compensation because of a job-related illness or disease is not filed until sometime after an employee has been separated from the employment rolls. When the ICPA receives such claims or a request from OWCP for employing activity documentation, it is important that as much information and documentation as possible concerning the employee's Federal employment and medical records, and any non-Federal employment or activity, be obtained and provided to OWCP. Upon receipt of a claim or OWCP request, the ICPA should:

(a) Complete SF-127, "Request for Official Personnel Folder (OPF) (Separated Employees)" and send it to the National Personnel Records Center (NPRC), 111 Winnebago Street, St. Louis, MO 63118.

(b) Complete SF-184, "Request for Employee Medical Folder," for employees separated after August 1984. For employees separated before September 1984, complete OF-11, "Reference Request - Federal Records Center."

(2) Follow-Up Actions. The ICPA should:

(a) Review the OPF, medical records, and DIUCS to extract as much information as possible to determine a possible employing activity position regarding the claimant's allegations.

(b) If the claimant had remained at the same employing office during the period of employment alleged to have caused the illness or disease (and the installation is still in existence), obtain documentation as would be available if the claimant were still employed.

(c) If the installation or organization is no longer in existence and exposure monitoring or other data has been destroyed or otherwise not available, request assistance from the DoD servicing liaison.

(d) A sample letter to OWCP showing types of information that an employing activity can provide is at Figure 32.

(e) The claimant's signature and date in blocks 15 and 18 of the current Forms CA-1 and 2, respectively, satisfy the requirements of any local regulation for written consent to release of medical information to OWCP to process a claim in which a person's medical history is relevant.

4. CONTINUATION OF PAY AND ACCOUNTING PROCEDURES

a. Continuation of Pay (COP)

(1) Coverage. The ICPA and supervisor must follow specific timekeeping and accounting guidelines. Accurate input of time and attendance is necessary in tracking injury compensation costs.

(2) COP Applicability. COP applies only to employees suffering traumatic injuries. Persons disabled because of occupational illnesses (those illnesses that are the result of continued exposure to a condition of the work environment) do not receive COP; they are only eligible for injury compensation benefits from the OWCP, and/or may use sick or annual leave or LWOP, as appropriate.

(3) COP - The 45-Calendar Day Period. COP is the continuation of an injured employee's regular pay for up to 45 calendar days with no charge to sick or annual leave. COP is charged in full days only and includes weekends and holidays. COP is paid by the employing activity and contributes directly to the cost of doing business in lost production time.

(a) Computation. The 45 days begin according to the appropriate one of the three rules provided below:

1. If the injury occurs before the start of the employee's scheduled tour of duty, the first day charged to COP is the date of injury. EXAMPLE: An employee whose tour begins at 9:00 A.M. is injured while entering the building at 8:50 A.M. on Tuesday. Tuesday would be the first day of COP.

2. If the injury occurs during the employee's scheduled tour of duty and immediate time loss results, the first day charged to COP is the first calendar day after the date of injury. EXAMPLE: An employee whose tour begins at 9:00 A.M. has a disabling on-the-job injury at 10:45 A.M. on Tuesday. The employee cannot return to duty for 5 days. Wednesday would be the first day of COP.

3. When the time loss is not immediate, the first day charged to COP is the first day of lost time following the date of injury. EXAMPLE: An employee is injured at 2:00 P.M. on Tuesday, is examined at the activity hospital, and returns to duty after the examination. At 10:00 A.M. on Thursday, the employee returns to the activity hospital for a follow-up. In this case, Thursday would be the first day of COP.

(b) Continuation-of-Pay Limitation

1. COP is calculated for each injury. One COP period is not added to another.

2. COP can be received only if the initial disability begins within 45 calendar days of the occurrence of the injury. In recurrence cases, COP is allowed if:

a. The initial claim had been previously approved or is pending OWCP adjudication; and,

b. The 45-day calendar days were not all used during the initial period of disability; and,

c. The recurrence is within 45 calendar days, beginning from the date the employee first returned to work following the first period of work stoppage.

(c) Partial Days Lost. If the employee stops work for only a portion of the day or shift, such day or shift shall be considered as 1 calendar day for purposes of counting 45 days. However, while such a day is considered 1 calendar day for counting purposes, the employee is NOT entitled to COP for the entire day or shift unless the physician advises (in writing) the employee to stay at home for the rest of the day. For example, if an employee who has returned to work uses 3 hours to receive physical therapy for the effects of the injury, the employee is entitled to only 3 hours of COP for that day or shift even though 1 full calendar day will be charged against the 45-day limit. If the employee is absent for all or any portion of the remaining 5 hours (assuming an 8-hour workday or shift), such absence is covered by leave - annual or sick leave, LWOP, or AWOL, as appropriate. Any absence during that day or shift beyond the time needed to travel to and from the therapy location and to obtain the physical therapy, cannot be charged to COP.

b. Authorization and Certification of COP

(1) Recurrence of a Job-Related Traumatic Injury

(a) An employee who suffers a recurrence of a job-related traumatic injury may elect to receive COP (if eligible), charge the absence to sick or annual leave, or take LWOP and file for injury compensation benefits from OWCP. COP is available as an option on:

1. If the 45 calendar days were not all used during the initial period of work stoppage; and,

2. If the recurrence is within 45 calendar days of the date that the employee first returned to work. If the recurrence occurs more than 45 calendar days after the employee returned to work following the initial work stoppage, COP may not be continued, even if some portion of the 45 days remains unused. In this case, the employee is entitled only to sick or annual leave or OWCP compensation.

(b) The phrase, "first returned to work" means the first return to any work, including part-time work. The first day of COP must be taken within 45 calendar days from the date of injury. The following example illustrates when the 45-day period begins from the date the employee "first returned to work" following the initial disability.

1. EXAMPLE: The employee is injured on January 2 and is totally disabled for 2days. On January 5 the employee reports to work and works a full day. The employee does not lose any time from work again due to the injury until February 8; is off work February 8, 9, and 10; and receives COP for those 3 days. The employee returns to work on February 11 and does not lose any further time from work due to the injury until March 20; but on March 20, 21, and 22 again loses time from work due to the disability. The employee would not be entitled to COP for time lost in March as it was more than 45 calendar days since the first return to work, which was January 5.

2. Once begun, COP is continued (if the 45-day period has not been expended) for the entire period of continuous disability, even though it extends beyond the 45 calendar-day period. However, all entitlement to COP for the injury ends after the first return to work thereafter (beyond the 45-day period).

(2) Authorization and Supporting Evidence. When an employee sustains an on-the-job traumatic injury, COP should be authorized pending receipt of the CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," and medical evidence. If the agency does not receive the completed CA-1 and prima facie medical documentation within 10 calendar days from the date the employee claims COP or the disability begins, whichever is later, COP shall be discontinued and the employee shall have his or her time charged to sick or annual leave or LWOP. (A completed CA-1 must be received within 30 days from the date of injury for the employee to be authorized COP.)

(3) Certification of COP. A physician's statement is necessary for all periods of absence due to an on-the-job injury. The treating physician should provide rationalized medical evidence

supporting the treatment provided and any period of disability causally related to the on-the-job injury. If the physician does not provide medical evidence, it may result in OWCP's denial of COP and be subject to recovery.

(4) Computing Employee's Pay for COP. COP is an employee's regular pay. It is the Employee's current weekly earnings excluding Sunday premium and overtime pay 5 USC 5546 (reference (n)). Firefighters and certain other employees are eligible to receive overtime when in receipt of COP (5 CFR Part 551) (reference (o)).

(a) An employee (full-time or part-time) receives COP for the number of hours (excluding overtime) he or she would have worked if he or she had not been injured.

(b) Intermittent, WAE (when actually employed) or part-time employees, either permanent or temporary, who do not work each week of the year (or period of appointment), receives COP in an amount equal to the average weekly number of paid hours that the employee has worked during the previous 52 weeks (excluding overtime). The weekly pay rate equals the average of the employee's weekly earnings during the 1 year before the injury. It is the total earnings divided by the number of weeks worked (partial weeks worked are counted as whole weeks). The annual earnings used for this computation must not be less than 150 times the average daily wage earned within 1 year before the date of injury (the daily wage is the hourly rate times eight). (Refer to Figure 33 for worksheet used to compute intermittent, WAE, or part-time employee's COP.)

(c) Normally, employees who would have been eligible to receive night differential or any other additional pay, excluding overtime or Sunday premium pay, will continue to receive these premiums while in COP status. However, a 1987 court decision requires firefighters to have overtime included in their COP. For computation information regarding firefighter pay-rates, please make reference to 5 CFR Part 550, Subpart M (reference (p).

(d) Employees normally entitled to holiday pay and a holiday falls within the 45-day COP period, the holiday will be counted against the 45 days.

(e) Particular attention to the physician's report is required when charging COP on Saturdays, Sundays, and other non-workdays. EXAMPLE: If the employee has a disabling on-the-job injury on Wednesday and the physician's statement says the employee cannot return to duty until the following Monday, Saturday and Sunday would be counted in this case.

(f) Any within-grade increases or promotions the employee receives are included in COP, since COP is replacement of the employee's normal salary.

(5) Election of Annual or Sick Leave. If an employee elects sick or annual leave instead of COP, he or she should be advised that such leave during the 45-day entitlement cannot be paid back by compensation and that this time counts against the 45 days of COP.

(6) Election Changed Within the 45-Day Period. An employee who first elected sick or annual leave on the Form CA-1 may change that election to COP for the entire COP period. EXAMPLE: An employee had an on-the job injury on June 20 and was totally disabled. The first day of COP would have been June 21, but the employee elected to use sick leave instead. Sick leave was charged from June 21 through 28 and the employee decided to use COP rather

than sick leave. A written request was submitted on June 28, so COP would be charged starting June 21. However, the employee must request the change to COP within 1 year of the date the leave was used or the date the claim was approved, whichever is later.

(7) First Aid Examination and Treatment for On-the-Job Injury or Illness. When management refers an employee to a medical unit (either on-site or off-site) due to illness or injury, all time spent waiting for and receiving medical attention on the workday on which the illness or injury occurs (that would otherwise have been worked, excluding overtime) is credited as work time. The supervisor so notes and initials the employee's timecard. This does not imply that an employee whose treatment extends beyond his or her scheduled tour of duty is to be credited for that time. An employee will be credited only for the number of regular hours he or she was scheduled to work that day (applicable to injuries that occur after the work shift has begun).

(8) COP Beyond Separation (General). COP may not be interrupted as part of a disciplinary action unless a preliminary notice was issued to the employee before the date of injury and the action becomes final or otherwise takes effect during the COP period. The ICPA must ensure that documentation is made available and that the preliminary notice was issued before the date of injury. COP is provided only through the date that the proposed action becomes final. If a disabling injury occurs just before the end of a temporary appointment and the employee was formally advised of the final date of the appointment before the injury, COP would be provided only through the date of termination. Where such notice was not issued before the date of injury, the agency will continue to pay COP. Formal notice of termination affects COP only; therefore Form CA-7 should be completed promptly and forwarded to OWCP, with the original CA-1 and other documentation.

(9) Pay Adjustments and Recovery of Overpayments

(a) Occasionally, OWCP may determine that an employee is not entitled to all or part of a period of COP that has already been given. The ICPA and claimant will be notified of such a decision and COP should be recovered accordingly.

(b) Upon receipt of the initial OWCP decision, the ICPA advises the employee, the employee's supervisor, and the civilian payroll activity that a corrected time and attendance document or data entry is needed to change COP to sick or annual leave, or LWOP, as elected by the employee. If LWOP is elected, the overpayment will be recouped by the payroll activity. An SF-52 will be submitted to document LWOP in excess of 80 hours when LWOP is taken for the purposes of receiving compensation benefits.

(c) Supervisors should submit an adjusted time and attendance document or input corrected data to the payroll activity to recover COP hours.

(d) When the COP adjustment has been processed, a letter should be sent to OWCP showing that the COP has been recovered.

(e) COP is not considered compensation, therefore, the cost of time charged to COP cannot be recouped in third party recovery cases.

(10) Light Duty Chargeable to the COP Period

(a) Normally, an employee performing light duty because of an on-the-job injury is not charged COP. However, COP is charged if an employee has been assigned light duty by an official personnel action (SF-50) and pay loss results. The employee must be furnished with documentation of the personnel action before the effective date of the action.

(b) When an employee is detailed to a work schedule entailing loss of night differential pay earned before the injury, COP days will be charged, even though the employee is working. The cost of COP is calculated as the difference between the employee's normal pay and pay earned in the detail position.

5. CONTROVERSION OF CLAIMS

a. Controversion. "Controvert" means to dispute, challenge, or deny the validity of the claim. For cases where entitlement to COP is not a consideration, the term controvert and challenge are used interchangeably.

b. General Guidelines

(1) Purpose of Controversion. The FECA provides for the controversion of an employee's claim for COP and compensation when there is reason to believe that the employee is not entitled to certain benefits under the law. It is the responsibility of all supervisors and ICPA's to dispute any injury compensation claim or element of that claim for which there is credible evidence of fraud, abuse, honest misjudgment by the employee, or any other circumstances that constitutes doubt as to the employee's entitlement to one or all benefits under FECA.

(2) Questionable Cases. In questionable cases, consult the supporting DoD liaison for an opinion on whether to withhold COP pending further developments in the case. For example, a temporary employee reports an injury sustained after having received notice of termination and there are no witnesses.

c. Types of Controversions

(1) Controversion of the Entire Claim. The entire claim should be controverted when there is reason to believe that the claimant is not entitled to the benefits he or she is claiming. These types of cases include fraudulent claims, honest misjudgment by the claimant as to job relatedness, injuries caused by willful misconduct and injuries proximately caused by intoxication.

(2) Partial Controversion. Any portion of a claim may be controverted when there is evidence to substantiate that the employee is not entitled to certain benefits under FECA. For example, an employee sustains a laceration to the right leg and the treating physician states that the employee is totally disabled for 2 days, but the employee takes off 4 days. Although it is a legitimate injury, 2 days of COP should be controverted, unless the claimant provides further evidence to justify the additional time.

(3) Controversion with Termination or Denial of COP

(a) The FECA provides that the employing activity may controvert and terminate or withhold COP on the basis of information submitted by the employee or secured on

investigation, if the claim falls into one of the following nine categories:

1. Disability results from an occupational disease or illness (see sample letter at Figure 34);

2. Employee is excluded by reference (a);

3. Employee is not a citizen or a resident of the United States or Canada;

4. Injury did not occur at the employing activity and the employee was not involved in official off-premises duties;

5. Injury was caused by the employee's willful misconduct, intent to cause injury or death of self or another person, or was caused by the employee's intoxication;

6. Claimant did not report injury on Form CA-1 within 30 calendar days following the injury (see sample letter at Figure 35);

7. Work stoppage first occurred 45 calendar days or more following the injury (see sample letter at Figure 36);

8. Employee initially reported the injury after employment was terminated (see sample letter at Figure 37); or,

9. Employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, Work Study Programs, or other similar groups. There is no entitlement to COP for these individuals; however, they may be entitled to compensation.

(b) These nine provisions are also listed in the instructions attached to the Form CA-1. These provisions should be reviewed carefully. It should be noted that OWCP makes the final determination and can overturn the activity's controversion of termination of COP.

(4) Termination of COP. Once COP has started, it may be stopped only if:

(a) Medical evidence is not received supporting the disability within 10 calendar days after the claim is filed by the employee;

(b) The attending physician has found that the employee is no longer disabled for the job held at the time of injury

(c) The attending physician advises that the employee is partially disabled and then the employee refuses a suitable written offer of light duty or fails to respond to such offer within 5 working days;

(d) The employee's term of employment expires, provided the date of termination of employment was established before the date of injury;

(e) A preliminary notice of disciplinary action was issued to the employee before the date of injury and takes effect during the COP period.

(f) The OWCP advises the agency to terminate COP; and,

(g) COP has been paid for 45 calendar days.

(h) The employee returns to work with no loss of pay.

(5) Controversion Without Termination or Denial of COP. If the conditions listed in 5.c.(1) of this enclosure do not apply, it may still be appropriate to controvert COP. However, the agency must pay COP to the claimant until notified otherwise by DOL.

(a) Reasons for controverting a claim that do not allow termination of COP are:

1. Facts of injury are questionable;

2. Medical evidence does not establish causal relationship;

3. Preexisting medical conditions if there is no medical evidence to explain how the injury affected the condition;

4. The results of claimant's fitness-for-duty examination conflict with the treating physician's medical report;

5. An employee delays reporting the injury (but still files within the 30-day time limit);

6. The claimant sustains a disabling injury after being refused leave;

7. The claim lacks substantiating medical evidence;

8. Diagnosis is not compatible with injury (see sample letter at Figure 38);

9. Injury was not caused by employment factors (see sample controversion letter at Figure 39).

(b) The FECA provides for controversion of traumatic injury, but does not specifically address occupational or recurrence claims. In these cases, it is the responsibility of the claimant to provide evidence that his or her condition is causally related to factors of employment. Although controversion, per se, does not apply in cases of occupational disease or recurrences, the activity can still question the validity or job-relatedness of a claim. Documentation is basically the same as for a controversion package; however, the claimant must submit a statement with the claim and the supervisor must comment on the accuracy of the statement. This gives the supervisor an opportunity to either substantiate or refute the information given (see Figure 40 for sample letter disputing an employee's claim).

d. The Employee's Burden of Proof. There are five basic criteria that OWCP considers in adjudicating a claim. Where the employee's evidence fails to meet any of the five requirements, the examiner will try to obtain clarification of significant discrepancies and any additional information necessary to reach a decision. It is the responsibility of the supervisor or ICPA to

controvert the claim if any of the following basic requirements are not established:

(1) Time Limitations

(a) Claimant should file a notice of traumatic injury or occupational disease claim for compensation within the time limits specified below. (These time limits apply only to injuries and deaths that occurred on or after September 7, 1974.)

(b) Reference (a) states that the claimant should file an original claim for compensation for disability or death within 3 years after the occurrence of the injury or death. Even if the claimant does not file within 3 years, compensation may be allowed if:

1. The immediate superior had actual knowledge (including verbal notification) of the injury or death within 30 days after occurrence; or,

2. The claimant gave written notice of injury or death within 30 days as specified in reference (a).

(c) Reference (a) also provides that filing a disability claim because of injury will satisfy the time requirements for a death claim based on the same injury. This section further provides that failure of any individual to comply with the 3-year time requirement may be excused by the OWCP on the grounds that notice of injury or death could not be given because of exceptional circumstances;

(2) Civil Employee. The injured employee or decedent must be or have been a Federal employee;

(3) Fact of Injury. The employee or decedent must have sustained an injury as defined in FECA;

(4) Performance of Duty. The injury or death must have resulted from an incident or circumstance occurring while the employee was performing official duties; or,

(5) Causal Relationship. The injury, disability, or death must have been caused by conditions of employment. The causal relationship may be either direct or by precipitation, aggravation, or acceleration of a preexisting or underlying condition.

e. The Controversion Package. The content and validity of a controversion package are the determining factors in OWCP's decision to uphold or deny a controversion. Therefore, it is of the utmost importance to prepare this package with care after thoroughly investigating the circumstances surrounding the claim. It is also important to mark the appropriate controversion block on the Form CA-1. The package should include a cover letter with documented evidence attached. The ICPA maintains a copy of the entire controversion package in the employee's claim file. A copy of the cover letter should be sent to the supporting DoD liaison for recording purposes.

(1) The Cover Letter. The cover letter is the first document the OWCP claims examiner sees and it summarizes the reason for controversion. All letters should be simple and tied to the FECA statute. Construct the letter to include:

(a) Introduction. The introductory paragraph should contain a reference to the claimant, the claim number (if assigned), the nature of the claim, and a statement that the claim or identified portion of the claim is being controverted;

(b) Presentation of Evidence. The body of the cover letter presents the actual evidence or reference to the evidence that supports the controversion. The body consists of two types of information:

1. Reference to the attachment; and,

2. Factual information not supported by attachment.

(c) The Summary. The final paragraph should contain a concise summary of the justification for the controversion and the action needed by the claims examiner; that is, the cover letter should:

1. Describe what is being controverted and why;

2. Support the agency's position; and,

3. State requested action.

(2) Attachments or Enclosures. The agency should support controversions with factual evidence and present that evidence as attachments. Refer to the attachments in the cover letter and arrange them in an orderly sequence.

(a) Examples of Attachments

1. Witness statements;

2. Supervisor's statements;

3. Medical evidence;

4. Diagrams, maps, or both;

5. Photographs;

6. Time and attendance records;

7. Other documents obtained during the investigation; and,

8. Investigative reports (if available).

(b) Importance of Attachments. Because the attachments make up the bulk of the evidence needed for controversion, their accuracy and completeness are vital. Documents refuting a claim or portion of a claim will weigh heavily on the adjudication of the case as long

as they are relevant, accurate, and objective.

6. PAY RATES USED FOR COMPENSATION AND OTHER PAY RELATED ISSUES

a. Compensation Pay Rate

(1) Compensation Pay Rate Explained. The pay rate used by OWCP for computing compensation is the highest rate on any of the following dates:

(a) Date of injury;

(b) Date of recurrence; or,

(c) Date disability began. This date applies for illness/disease claims.

(2) How to Determine Pay Rates

(a) Date of Injury Pay Rate. The date-of-injury pay rate is the rate used in most claims. The hourly rate should be provided if the employee is paid on this basis. OWCP will multiply the hourly rate times 2087 and divide by 52. The annual pay rate should be used if employee is paid on an annual basis. If an annual rate is used, OWCP will divide this amount by 52, in accordance with the "FECA Procedure Manual," (reference (q)).

(b) Date Disability Began Pay Rate. This is the pay rate used when the employee did not stop work on or immediately following the date of injury and the disability began later. The date-disability-began pay rate is compared to the date-of-injury pay rate and the greater of the two is used.

(c) Date of Recurrence Pay Rate. In order for an employee to receive the recurrence pay rate, the recurrence must begin more than 6 months after the employee had resumed regular full-time employment with the government. The 6 months begin after the employee has lost time other than the date of injury. The employment with the government during the required 6 months need not have been continuous. The 6-month requirement applies only to the first recurrence of disability and is not a requirement to subsequent recurrences.

(3) Temporary Employees. In certain situations, temporary employees are not entitled to compensation at the same rate as full-time, permanent employees. If an employee's appointment was for less than 1 year, the ICPA must submit the additional information to OWCP as follows:

(a) How long was the appointment, including extensions? Submit copies of all applicable SF-50s.

(b) Had the employee established the ability to work full time? Submit a copy of an "Application for Employment."

(c) What were the annual earnings of a similar employee (another 90-day appointee, NOT a full-time permanent employee)?

(4) Computation of Compensation for Intermittent and Temporary Employees. Normally, OWCP bases compensation on the employee's weekly pay at the time of injury. However, if the employee was on an intermittent or temporary job that would not have afforded employment for a whole year, OWCP may use a different formula to compute the weekly pay rate. In these cases, the average annual earnings used as the basis for compensation will not be less than 150 times the employee's average daily wage earned in the particular employment during the year immediately preceding the injury. (EXAMPLE: An employee earning $7.32 per hour - $7.32 per hour X 8 hours = $58.56 (per day) X 150 = $8,784.00 (per annum) divided by 52 weeks = a weekly pay rate of $168.92.)

(5) Firefighters and Employees Who Work Other Than a 40-Hour Workweek. For firefighters (and other employees) who work other than a 40-hour workweek, it is critically important that OWCP be specifically advised of: (1) the actual number of hours in the workweek, listing regular and overtime hours separately; and, (2) the basic pay rate, the overtime pay rate, and percentage of premium pay. The ICPA must include a statement about whether the provided pay rate includes or does not include the premium pay. For firefighters who work 72 hours per week, overtime is paid for 19 hours. The overtime pay is included in the pay rate used for compensation purposes (reference (o)). The formula for computing premium and overtime pay is included in Figure 41. The ICPA should complete the worksheet and forward a copy with the claim to OWCP.

(6) Cost of Living Increases. The FECA provides for increases based on the Consumer Price Index (CPI) to claimants who have been receiving compensation for more than a year. CPI increases apply only if the claimant received compensation before March of the previous year. Figure 42 contains all the CPI adjustments granted since 1966 and can be used in determining if the amount of compensation paid to the claimant and charged back to the activity is reasonably correct.

(7) Loss of Wage-Earning Capacity

(a) When an employee has a partial loss of wages, OWCP will compute the compensation based on the "Shadrick" formula as it reflects the principles declared by the Employees' Compensation Appeals Board (ECAB) in the case of Albert C. Shadrick, 5 ECAB 376. In that decision, the ECAB found that reference (a) does not say that compensation is to be based on the difference between the employee's earnings at the time of injury and whatever variable dollar income the employee may have in the future. Instead, it is to be based on the loss of capacity to earn wages. The ECAB went on to say, "Although capacity to earn and not wages received is the proper test under the law, an employee's actual wages may constitute compelling evidence of his capacity to earn and in a proper case may be used as a yardstick in determining an injured employee's diminished earning capacity." However, in applying this yardstick, the Appeals Board found that "... wages received 2, 5, or 10 years after an employee has sustained an injury and during which period changes in business conditions have caused wages to double due to a business boom or to be cut in half due to a depression cannot be used as a conclusive factor in determining a claimant's diminished wage-earning capacity after he has been injured." The Appeals Board concluded that "Actual dollar earnings received several years after injury may be used to determine wage-earning capacity only after they have been converted into terms of actual dollar earnings received at the time of the injury."

(b) Mathematically, this principle is represented by the "Shadrick" formula as shown in

Figure 43. When the job held at the injury included additional elements of pay that would be reflected in the pay rate for compensation purposes, such as night differential, such additional pay must be reflected in the current pay for the same job. This is done by increasing the current base pay by the same percentage as the original base pay was increased by the additional pay elements.

b. Preventing Overpayment Occurrences. To prevent overpayments, the ICPA should:

(1) Submit a copy of the SF-50 reflecting the salary on the date of injury with the initial CA-7;

(2) Highlight part-time or intermittent employment on Forms CA-1, CA-2, or CA-7;

(3) Avoid completing the employee's portion of Form CA-7. If there is fraud, the government does not have a case if the form was not completed by the claimant;

(4) Review the award letters on schedule awards and compensation payments to insure that the correct pay rates were used; and,

(5) Review leave buy-back cases and verify that the CPIs are not given if the pay rate was not in effect for 1 year as of March 1 on the following year.

c. Leave Buy-Back Procedures

(1) Criteria for Leave Buy-Back. If an injured Federal employee elects to use sick or annual leave during a period of disability, the employee may (with agency approval) claim compensation for the period of disability and "buy back" the leave used. Compensation for leave repurchase is computed in the same way as compensation for temporary total disability. Since leave is paid at 100 percent of the usual wage rate, while compensation is paid at either 66 2/3 percent or 75 percent of the employee's usual pay rate, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency. The employee's leave record must be changed to leave-without-pay (LWOP) for compensation to be paid. Since leave is not earned during a period when an employee is in a LWOP status, the repurchase of leave may result in a reduction of earned leave. Buy back of leave is subject to agency concurrence and availability of official leave records (any sick or annual leave used during the 45 day COP period cannot be used for leave-buy-back purposes unless the employee was not entitled to COP). Before leave buy-back procedures begin, the following criteria must be met:

(a) OWCP has approved the employee's claim for compensation benefits.

(b) The employee used sick or annual leave due to the disability.

(c) The claim for leave buy-back is submitted within 1 year of the date the leave was used or the claim was accepted, whichever is later. (This would assure leave records and medical documentation are available to support disability for the period claimed.)

(d) Requests for leave buy-back shall be submitted for a minimum of 10 hours of leave unless no further claims are anticipated. Medical documentation must be provided for all

dates claimed.

(2) How to Process Leave Buy-Back Requests. The following are procedures to use when an employee buys back leave:

(a) When an employee advises his or her immediate supervisor or other designated official of intention to file a leave buy-back claim, the employee should complete a CA-7 for the dates claimed. When more than one continuous period of leave is claimed, the employee should complete a CA-7a, "Time Analysis Form," (Figure 44) following the instructions (Figure 45).

(b) The employee completes the forms and returns them to the supervisor or designated official. After completing the agency's portion, the supervisor or other official forwards the form to the ICPA.

(c) The ICPA reviews the CA forms and reviews and CA-7a for accuracy of hours shown, verifying the hours against payroll records. The ICPA should contact the employing agency's payroll department to obtain the total repayment amount for all hours claimed. The determination as to which hours are actually compensable will remain an OWCP function, based on review of the medical evidence on file.

(d) The ICPA estimates the FECA entitlement using CA-7b, "Leave Buy-Back (LBB) Worksheet/Certification and Election" (Figure 46). Part II of the CA-7b will be completed by DFAS. The completed worksheet will show the total repurchase amount, the estimated amount OWCP will pay if all hours are approved, and the balance which the employee will be required to pay to the employing agency.

(e) The ICPA returns the CA-7b to the employee. The employee reviews the figures provided and determines whether to pursue the leave buy-back request.

1. If the employee decides not to pursue the request, he or she will check the "No" box on the CA-7b, sign the form, and return it to the ICPA. The employing agency will retain the claim rather than forwarding it to OWCP.

2. If the employee decides to pursue the request, he or she will check the "Yes" block on the CA-7B, sign the form, and return it to the ICPA. The ICPA will also sign the form and forward the complete package, consisting of the CA-7, CA-7a (if applicable), and the CA-7b, along with any medical documentation submitted by the employee, to OWCP.

(f) The FECA District Office will review the estimate of FECA entitlement shown on the CA-7b. If there are no discrepancies greater than 10 percent (reference (q)), the leave repurchase request will be processed like a regular compensation payment. The employee is not required to repay the employing agency until compensation has been approved by OWCP.

(g) After leave buy-back has been approved and paid, the ICPA should determine whether the leave was used but a tax return has not been filed for that year. If so, the employee should be advised to request an adjusted W-2 from Payroll. Figure 47 illustrates a leave buy-back flow chart outlining the process.

(3) Impact on Leave Forfeiture and Leave Earnings. If annual leave is to be recredited to

the employee's account and it exceeds the maximum permissible carryover balance, the excess amount is subject to forfeiture. Since the leave previously used must be converted to LWOP for "buy back" purposes, leave earned during the buy-back period is nullified. In addition, the employee will no longer be entitled to pay received for any holiday that was included within the period of LWOP and each increment of 80 hours LWOP results in a corresponding loss of leave accruals.

(4) Debt Collection. Title 29 Code of Federal Regulations, Part 20, Subpart D, "Federal Claims Collection" (reference (r)) authorizes agencies of the Federal Government to refer debts to private collection agencies for collection and to assess interest, penalties, and administrative costs.

d. Projecting Lifetime Compensation Costs. Reemployment of injured workers is one of the most effective means of reducing program costs. Providing managers and supervisors with realistic potential lifetime costs (potential liability to the Department of Defense) can be effective in gaining their support in the return to duty of injured employees. Figure 48, with accompanying instructions and tables (Figure 49), can be used to determine these costs.

7. RETENTION, REEMPLOYMENT, AND REHABILITATION

a. General Guidance. This section tells how to keep an injured employee actively employed and how to help an employee who has partially recovered from a job-related injury to overcome his or her disability and return to work as early as possible. (The term "employee" as used in this section includes individuals receiving FECA benefits who have been separated from DoD rolls.) The intent is not only to provide the injured employee with productive employment, but also to reduce or eliminate the DoD compensation costs. A single employee retained in an active employment status or returned to duty can result in a lifetime savings to the Department of Defense of hundreds of thousands of dollars and depending on age, over one million. Management and civilian personnel should make every effort to place the injured employee in a position appropriate to his or her medical limitations. A common characteristic of successful programs is the recognition of the need to involve all participants in the process, i.e., classification, affirmative employment, employee relations, manpower, and medical services.

b. Early Case Management Actions. OWCP uses the services of registered nurses to decrease the extent and duration of disability by improving medical management in cases where projected length of disability is uncertain. The nurses meet with injured employees, treating physicians, and employing agency representatives to address questions about medical care, treatment plans, return to work dates, descriptions of work limitations, and availability of light duty jobs. Usually, nurses are assigned to claimants with injuries such as back sprain/strain, neck or shoulder sprain/strain, knee injuries, and carpal tunnel syndrome after the 45-day COP period has ended and a Form CA-7 has been filed with OWCP. However, the ICPA may request nurse intervention services when they believe the services would be beneficial in the medical management of long-term cases. A contract nurse:

(1) Communicates directly with injured workers and their families to explain and monitor medical treatment and progress;

(2) As needed, identifies and pursues more active treatment or more active participation by the injured worker;

(3) As requested by the claims examiner, obtains concrete work limitations;

(4) Arranges for on-site visits to the work place;

(5) Communicates directly with the treating physician about light duty opportunities and other issues; and,

(6) Initiates return to work programs with the employee, agency and treating physician. ICPA's should promptly submit all claim forms and related material to OWCP to ensure timely assignment of cases to the Nurse Intervention Program.

c. Actions Required Before or When Employees Are Separating From the Employment Rolls. If an employee has sustained a job-related injury or occupational illness and is receiving any FECA benefits, or is in the process of filing or may file a claim later (as in the case of a hearing loss), the following actions are mandatory by the agency.

(1) When the employee is filing for disability retirement, the agency must:

(a) Make every effort to place the employee in a position compatible with the physical limitations resulting from the injury or illness and any preexisting conditions. The position can be any available permanent full-time or part-time (if the employee is unable to work full-time) job, which the employee can perform regardless of the grade or rate of pay;

(b) Send a letter to the employee's physician explaining the differences between the Workers' Compensation Program and the Civil Service Retirement System (CSRS) or Federal Employees' Retirement System (FERS). Make sure the letter contains a request for the physician to provide information regarding the employee's current work limitations and restrictions. Refer to the sample letter in Figure 50 for this purpose;

(c) Document all actions taken to place the employee based on his or her physical restrictions and to meet the "reasonable accommodations" obligations. (See glossary for definition of reasonable accommodation.);

(d) Identify a position and offer it in writing to the employee. Make sure the offer includes a description of the duties to be performed, the specific physical requirements, any special workload demands or unusual working conditions, the pay rate, the organization and geographical location, the hours of work, the date when the job will be available, and date of expected response. (Refer to Figure 51 for sample job offer letter.); and,

(e) Have the employee accept or decline in writing. If the employee declines, include the reasons for declining and a statement that he or she understands that declining may affect entitlement to FECA benefits and OPM disability retirement.

(2) When an employee voluntarily resigns or applies for optional retirement, the agency must:

(a) Obtain a copy of the employee's current position description, including

the precise physical requirements; and a signed statement from the supervisor concerning the employee's past performance, the continued availability of the position, and the expected continued performance of the employee were he or she to remain on the job;

(b) Obtain a copy of the employee's SF-52 showing the signed statement of the employee's reason for resigning; and

(c) Maintain a copy of the above documentation, in addition to a copy of the separation SF-50 in the working case file and forward copies to OWCP.

(3) If the employee's separation results from other reasons such as reduction-in-force, functional transfer, failure to qualify during the probationary period, failure to meet the requirements of the Veterans Re-Adjustment Act (VRA), or disciplinary actions not related to on-the-job injury or illness, as applicable, the agency must:

(a) Obtain a copy of the employee's current position description, including the precise physical requirements, the salary of the position, and a signed statement from the supervisor concerning the employee's past performance, and the expected continued performance of the employee had it not been for the reduction-in-force;

(b) Provide a statement concerning the entitlement to relocation expenses, if functional transfer is involved;

(c) Obtain documentation (including disciplinary actions) concerning the reasons unrelated to the on-the-job injury or illness that caused the action;

(d) If the employee was offered and declined a functional transfer, obtain a copy of the position description including the precise physical requirements, the salary, and a signed statement from the employee showing that he or she understands his or her nonacceptance may negate any entitlement to compensation payments in accordance with reference (a); and,

(e) Maintain a copy of the above documentation, in addition to a copy of the separation SF-50 in the working case file and forward copies to OWCP.

d. Reemployment Actions

(1) Exception to Hiring Freezes. By direction of the Secretary of Defense, heads of DoD Components have authority to exempt claimants from hiring freezes. Reemployment of claimants makes sound economical sense by eliminating or reducing nonproductive expenditures (compensation payments) and, in turn, receiving services for expended dollars.

(2) Reemployment Efforts

(a) The OWCP Rehabilitation Specialist (RS) has the responsibility to review and screen all compensation case files to determine if an injured worker can be considered for reemployment. The RS bases his or her determination on the results of a current medical evaluation and an interview with the employee. If the RS decides that the injured worker is a potential candidate for reemployment, he or she may refer the injured worker to a private

counselor for possible vocational rehabilitation. The RS also sends a copy of the referral letter to the claimant's previous employer for possible placement.

(b) Although the OWCP has the primary responsibility of making referrals to the employing agencies, the CPO/HRO, physicians, management, supporting DoD liaison, or the injured employee may initiate reemployment efforts. For instance, the ICPA should carefully screen the case files of employees listed on the chargeback report to determine if there are potential rehabilitation or reemployment candidates receiving compensation.

1. If, after careful review of the case file, it appears a claimant can perform some type of work in a limited capacity, the ICPA should immediately send a letter (see sample letter at Figure 47) to the employee requesting that he or she complete an "Application for Federal Employment." The ICPA should coordinate this letter with the appropriate affirmative employment specialist.

2. When a separated employee has relocated outside the commuting area, the activity should investigate possible employment opportunities in his or her current area. If a suitable offer for employment in a Federal position cannot be made in the former employee's current location, OWCP may pay reasonable and necessary relocation expenses. These expenses are later charged back to the DoD Components.

3. Assisted reemployment may be appropriate if a suitable position in private industry or in another Federal agency is identified in the former employee's current area. This OWCP project provides for 3 years of partial reimbursement of salaries to employers, other than the original employer, who reemploy disabled workers receiving FECA compensation.

4. Telework shall be considered an appropriate alternative to traditional placement in the work locale.

5. If assistance is needed in placing the employee or former employee, the ICPA should request the supporting DoD liaison or the OWCP RS to review the case file to evaluate the possibility of an official referral. In the reemployment process, it is not always necessary to have OWCP rehabilitation involved.

(3) Preparing for Appointment

(a) As soon as the ICPA, liaison, or RS initiates a reemployment referral action, the employment specialist should request and review the employee's OPF and medical records to identify all positions for which the employee qualifies.

(b) Based on the "Application for Employment," the employment specialist should search all current and anticipated vacancies for possible placement. Where accommodations are necessary (based on the employee's partial disability), managers should consider creating a position meeting the employee's medical limitations.

(c) The employment specialist should contact organizations where placement is anticipated and provide the OWCP Form 5, "Work Capacity Evaluation," the qualifications statement, and any other pertinent information regarding the employee's work capability. The

employment specialist should advise the organization that an overstrength position may be requested for this special placement through the Pipeline Reemployment Program.

(d) If a position description is needed, the supervisor and classification specialist should develop one (using the Factor Evaluation System format) accommodating the employee's physical and environmental limitations. If the current position description is modified, a detailed position review should be attached as an addendum describing the physical and environmental demands of the position in relation to the limitations set forth on the OWCP Form 5. Staffing personnel will clear placement priorities before the action.

(e) The activity (or nearest) medical officer will review the OWCP medical evaluation, the OWCP Form 5, any preexisting medical condition, and any medical condition that may have developed after the employment injury to make a recommendation regarding employability. The CPO/HRO should evaluate the referral, documented medical limitations, and the medical officer's recommendations, and decide whether to make a job offer. If the CPO/HRO requires updated medical information to determine whether a position is within the employee's medical limitations, the request should precede the offer of employment. It should include the same information about the duties and physical requirements of the position as would be included in the offer of employment.

(f) The CPO/HRO has the option of obtaining the attending physician's approval before making the official job offer. The ICPA should transmit the following to the employee's attending physician for approval:

1. A description of the position being offered clearly defining the specific duties and the specific physical requirements (SF-78).

2. If possible, a brief cover letter signed by a DoD Component medical officer or the CPO/HRO.

(4) Restoration Rights. Restoration rights apply to all employees, except those serving under a time-limited appointment. When an employee has been separated from the agency rolls due to disability from a job related injury, the following applies:

(a) Rights For Those Fully Recovered Within 1 Year

1. A disabled employee has mandatory restoration rights for a period of 1 year from the date compensation begins. The 1-year period begins the date compensation is payable. The 45-day period of COP is excluded since this is not considered "compensation." Also excluded is any period of sick or annual leave the employee elects to take; and,

2. The employee shall be restored immediately and unconditionally to the former position or, with the employee's concurrence, to an equivalent position in the commuting area in which the employee was formerly employed;

(b) Rights For Those Fully Recovered After 1 Year. An employee, who takes longer than 1 year to recover and who has been separated from work because of injury or occupational disease, is entitled to priority consideration for the former position or an equivalent one if the employee applies for restoration within 30 days of the date compensation ceases or 30 days from

the resolution of an appeal for continued compensation;

(c) Physically Disqualified. An employee who is physically disqualified for the position previously held or an equivalent position, is entitled, within 1 year of the date compensation begins, to be placed in a position for which he or she is qualified that most closely approximates the seniority, status, and pay to which the employee would otherwise have been entitled, consistent with the circumstances in each case. After 1 year, the employee is entitled to the rights accorded employees who fully or partially recover, as applicable;

(d) Partially Recovered. A partially recovered employee has no right to restoration. However, every effort shall be made to place the employee in an appropriate position in the commuting area. This shall include re-engineering the former position, if feasible, or placing the employee in any other position he or she is able to perform; and,

(e) Status Upon Restoration. An employee who is restored following a compensable injury or disease is treated as though he or she had never left; however, an employee does not earn sick and annual leave while off the rolls or in a non-pay status. The entire period the employee was receiving COP or compensation is creditable for purposes of rights and benefits based on length of service, including within-grade increases, career tenure, and completion of probationary period.

e. The Official Position Offer

(1) Position Availability. When making an offer of employment, the CPO/HRO must ensure that the offered position shall be available during the period required for OWCP to advise the employee of suitability and to allow for the employee to respond. An employee might refuse a job offer initially, but accept the offer after receiving a letter from OWCP.

(a) If the job is not available at the time the employee accepts the offer, OWCP will find that suitable work was not available and benefits will continue.

(b) The success of efforts to return employees to gainful employment while providing procedural due process requires close cooperation among the activity, supporting DoD liaison, and OWCP. Early notification of job offers and complete information about the physical and other requirements of the job will aid OWCP in making its decisions.

(2) Meeting the Test of Suitability. To meet the test of suitability under FECA, the job offered must be within the physical capabilities of the employee. Generally, when an employee can work 4 or more hours a day and the position offered is for less than 4 hours, OWCP shall find the position unsuitable because less than 4 hours a day is regarded as sheltered employment and is reserved for the severely disabled. In these instances, OWCP encourages the employer to consider whether it can provide longer hours to the employee or place the employee in another position. Other instances in which OWCP will find a light duty job offer to be unsuitable include:

(a) Permanent Seasonal Employment. Generally unsuitable unless the claimant was a career seasonal or temporary employee when injured. In locations where year-round jobs are scarce, however, a seasonal position may be considered suitable for an employee who previously held a year-round job. In either case, the job must reasonably represent the claimant's WEC.

(b) A Temporary Job. Unsuitable unless the claimant was a temporary employee when injured and the temporary job reasonably represents the claimant's WEC. Even if these conditions are met, according to reference (q), a job which will terminate in less than 90 days will be considered unsuitable.

(c) A Condition Arising Since the Compensable Injury. If medical reports in the claimant's file document a condition that has arisen since the compensable injury, and this condition disables the claimant from the offered job, the job will be considered unsuitable (even if the subsequently-acquired condition is not work-related).

(3) Employment Offer

(a) The offer of employment should contain:

1. A description of the duties to be performed. (A copy of a position description may be attached, but the duties of the position must be described in narrative form within the job offer letter, title, series, grade, step, rate, and salary of the position);

2. The specific physical requirements of the position, tour of duty, hours of work, or both, and any special workload demands or unusual working conditions;

3. The date the job will be available and the expected term of the position (at least 90 days);

4. The organizational and geographical location of the job;

5. The date by which a response to the job offer is needed (the suggested time period is 15 days);

6. If applicable, information regarding loss of wage earning capacity benefits;

7. A statement that the job will remain available until OWCP makes a formal determination that the job offer is valid; and,

8. The attending physician's approval of the physical requirements for the claimant.

(b) Sometimes it is not possible to offer an employee a job at his or her current grade level or the last grade held before being separated from the agency rolls. If the individual is reemployed at a lower grade or pay level than previously held, OWCP will make up the difference by determining and paying loss of wage-earning capacity (LWEC) benefits. This costis charged back to the agency. It should be noted that pay retention tends to disguise the actual cost of work injuries. When the pay LWEC is paid by the OWCP, the costs associated with the injury are clearly identifiable.

(c) The notice to the employee about the job offer should not include a request for election of OPM benefits if the employee decides not to accept the job offer. OWCP shall not consider the employee to have made an informed election of benefits unless the OWCP advises

the employee that the job is suitable and the consequences of a refusal without reasonable cause. OWCP will offer an election between OPM and OWCP benefits (see Figure 51, Sample Letter and Acceptance or Declination Statement).

(d) The ICPA should send complete copies of the letter offering employment to the OWCP claims examiner, the supporting DoD liaison, and if appropriate, the rehabilitation specialist, at the time the offer is made.

(e) On receipt of the job offer, with the duties and physical requirements specified in it, the OWCP district office will evaluate the position to determine whether it is suitable, medically and otherwise. If the job offer is suitable, OWCP will advise the claimant and afford him or her 30 days to submit any evidence to the contrary or reasons for refusing the job. OWCP shall provide this advice even if the CPO/HRO has informed the claimant of his or her responsibilities and of the sanctions that may be imposed. OWCP will transmit a copy of the job offer with the duties and physical requirements to the employee.

(f) If OWCP determines the job offer is not suitable, OWCP shall notify the CPO/HRO and provide assistance in identifying other accommodations to make the job offer suitable.

(4) Job Offer Acceptance. If the employee accepts the job offer, the CPO/HRO notifies OWCP as soon as possible of the return-to-duty date. Benefits will be terminated or adjusted as of the date of return to duty. To avoid overpayments of compensation, the ICPA notifies OWCP of the employee's return to work by telephone, and submits a copy of the appointment SF-50.

(5) Job Offer Refusal. If a former employee declines a valid job offer, the CPO/HRO must send a copy of the employee's declination with the reasons for declining to OWCP. If the employee refuses to sign a declination, the ICPA must document this information in a letter and forward it to OWCP. If the employee refuses the offer, but provides reasons to support the refusal, OWCP shall evaluate the reasons given and decide whether the refusal is valid.

(a) If the reasons are not valid, OWCP shall send another letter to the claimant providing 15 more days to accept the offer and issue a warning that the compensation order to terminate benefits (except for medical expenses) will follow. The claimant's benefits will not be terminated until the additional 15 days have passed.

(b) If OWCP cannot determine whether the former employee's reason for refusal is justifiable without further investigation of the issues, OWCP will ask the claimant for clarifying information and set a 30-day deadline. The OWCP will take no action until it receives a response from the claimant or the OWCP 30-day notice period has expired. If the employee does not respond to OWCP's letter, OWCP will issue a compensation order to terminate benefits under reference (a) on the basis that the employee refused suitable work.

(c) If reasons for refusal are valid, OWCP shall advise the CPO/HRO and continue compensation at a level commensurate with the degree of disability.

f. Retirement Credit for Time Spent in Receipt of OWCP Benefits

(1) Retirement Credit Explained. When a current or former employee returns to Federal employment, different provisions apply in crediting the time spent while receiving OWCP

benefits toward retirement. The following categories explain when the time is creditable and the requirements to be met for the credit. (OPM Operating Manual, Section 102.A.3. of the CSRS and FERS Handbook for Personnel and Payroll Offices (reference (s)).

(a) Employee in a LWOP Status. An employee who is in a leave-without-pay status while in receipt of FECA benefits will receive full credit for the LWOP period in the computation of annuity and for high-3 average salary purposes. LWOP while in receipt of FECA benefits is not subject to the limitation of 6 months' credit in each calendar year, as is other LWOP. The "one-out-of-two provision" does not apply when an employee is in a LWOP Status. (See 7.f.(1)(b) of this enclosure.)

(b) Separated Employee. This category applies to a former employee whose optional, disability, or discontinued service retirement has not been approved. When a separated employee (other than an annuitant) returns to Federal service, that portion of the period of separation during which the employee receives FECA benefits is deemed to be a period of LWOP and is fully creditable for computation and high-3 average salary purposes. The official personnel folder will be reconstructed for the periods of time separated, documenting all pay adjustments and step increases as if the employee had been on the agency rolls. No period of separation, even one in which the employee received FECA benefits, may be credited in meeting the requirement that a CSRS employee complete 1 year of covered service in the 2-year period immediately preceding a non-disability retirement. THE "ONE-OUT-OF-TWO" REQUIREMENT DOES NOT APPLY UNDER FERS.

(c) Disability Annuitant Under Age 60. This category applies to an individual who has filed an application for retirement with OPM and who is entitled to an annuity whether or not an annuity has ever been received. This person would be considered an annuitant. The reemployment status of a disability annuitant is determined by the continuing nature of his or her disability annuity. A reemployed disability annuitant can receive service credit for the time spent on OWCP's rolls if he or she:

1. Subsequently returns to work in a position with retirement coverage;

2. Is found by OPM to be either:

   a. Recovered from disability; or,

   b. Restored to earning capacity; and,

3. Establishes a new entitlement to annuity. EXAMPLE: A disability annuitant who retired from a GS-9 full-time position is awarded OWCP benefits. Later, the annuitant is reemployed in a permanent, full-time GS-9 position, and the OWCP benefits are terminated. OPM finds the reemployed annuitant recovered from his or disability 3 months after reemployment. Ten months later (sufficient time for a CSRS employee to meet the 1-year-out-of-two requirement), if the employee met the age and years of service eligibility, he or she would be eligible for retirement. The period of separation spent in receipt of OWCP benefits is creditable in determining entitlement to the benefit.

(d) Disability Annuitant Age 60 or Over. A disability annuitant, age 60 or over, may be found recovered only on his or her own request. However, an annuitant's request cannot form

the sole basis for a recovery finding. There must also be evidence of medical recovery or equivalent employment.

(e) Not Found Recovered/Restored by OPM

1. Disability Annuitant. If the disability annuitant/OWCP recipient is not found by OPM to be recovered or restored, he or she is treated differently when reemployed. In these instances, the reemployment service is governed by the provisions of the law covering reemployed annuitants. Thus, the period of separation during which the individual received OWCP benefits (instead of a disability annuity) is not creditable unless he or she is reemployed for 5 continuous full-time years (or the part-time equivalent) and elects a redetermined annuity. To qualify for a redetermined annuity, an annuitant must actually serve the equivalent of 5 years of full-time service. This entitles the annuitant to recomputation of his or her annuity, as of the date of the later separation, crediting all prior service. If the annuitant is not employed for the equivalent of 5 years of full-time continuous service, he or she would be eligible for a supplemental annuity. To qualify for this, an annuitant must actually serve the equivalent of 1 year full-time, continuous service in the reemployed position.

a. Part-time service is prorated. This would entitle the individual to an additional sum of money, added on to the original annuity, proportionate to, and giving credit for only the actual time served. No credit is given for the period in receipt of OWCP benefits for a supplemental annuity. A non-recovered disability annuitant must earn a redetermined annuity to credit post-retirement time spent on the rolls of OWCP.

b. Upon receipt of verification of an annuitant's reemployment, OPM reviews the records to determine the effect, if any, on the individual's continuing eligibility for benefits based on disability. However, continued payment from OWCP for loss of wage-earning capacity is prima facie evidence that the person is not recovered. In such cases, OPM will not make a finding of recovery unless there is contravening medical evidence.

2. Non-Disability Annuitant. The reemployment status of a non-disability annuitant is determined by the provisions of reference (e).

a. If the individual's right to an annuity continues during reemployment, the individual cannot credit a period of separation during which he or she received OWCP benefits unless he or she is reemployed for 5 continuous full-time years (or the part-time equivalent) and elects a redetermined annuity.

b. If the individual's right to annuity ceases on reemployment in a covered position, the period of separation during which he or she received OWCP benefits is not creditable unless he or she establishes a new annuity right based on reemployment service. (Under CSRS, this would require that the employee meet the "one-out-of-two" requirement.)

(2) OPM Notification Upon Reemployment. OPM should be notified immediately when an annuitant is reemployed.

8. FRAUD AND ABUSE

a. Fraud and Abuse Explained. This section provides injury compensation personnel with general criteria to apply in identifying and documenting suspected fraud and abuse in the FECA Program. This section also establishes a uniform procedure for referring suspected claims to the DOL Inspector General (IG) and/or other investigative services.

(1) Fraud and Abuse Program Objectives

(a) Reduce compensation costs resulting from fraudulent and abusive claims.

(b) Assist ICPA's in obtaining evidence regarding employees who may be defrauding or abusing the FECA.

(c) Properly document and follow through with appropriate action. Such actions may include:

1. Disciplinary action;

2. Advising OWCP for administrative action;

3. Referral to DOLIG or other investigative services; and,

4. Appropriate prosecution in the criminal court system.

(2) Fraud and Abuse Defined

(a) Fraud. The intentional deceptive act, or series of acts, committed by an individual with the specific intent to cause the Department of Defense or OWCP to grant benefits under FECA that would not normally be provided. Example: Faking an injury, concealing the fact that an injury occurred off duty, failing to report other employment, etc.

(b) Abuse. Excessive, extravagant, or wrongful use of FECA in a manner contrary to its legal intent to acquire additional benefits for personal gain. Example: Prolonging the length of recovery period caused by a job-related injury. Although the terms "fraud" and "abuse" are related, they are not interchangeable. Any time employees apply for, or receive, FECA benefits to which they are not entitled, they may be abusing FECA. It may be because the employees have an ignorance of the law and its provisions or because they believe that they are genuinely entitled to those benefits. When employees knowingly apply for FECA benefits they know they are not entitled to, they are committing fraud. The key difference between fraud and abuse is intent. Abuse may not always be fraud, but fraud is always abuse.

b. Detecting Fraud and Abuse Claims

(1) Fraud and Abuse Indicators and Warning Signals. In processing or reviewing a compensation claim file, several warning signals or indicators of fraud or abuse can be found. The existence of these signals or indicators does not prove fraud or abuse. They do indicate, however, that the facts surrounding a particular claim merit further inquiry or investigation.

(This list is illustrative and not inclusive. Refer to Figure 52.) Several warning signals or indicators of fraud or abuse have been identified and are listed below:

(a) Employee regularly participates in physically demanding activities (sports, farming, military reserve duty, etc.);

(b) Medical treatment or documented diagnosis is not consistent with the nature of the claimed injury;

(c) Employee changes physicians for unexplained or irrational reasons;

(d) Employee has secondary employment (injury may have been caused by the secondary employment);

(e) Injury occurs at start of duty Monday, end of duty Friday, or immediately before or after scheduled leave or a holiday;

(f) Injury occurs after notification or announcement of functional transfer, reduction-in-force or base closure;

(g) Injury occurs near termination of temporary employee tenure;

(h) Injury occurs after a leave request is denied (obtain a copy of the SF-71, "Application for Leave," or a signed statement from the supervisor or person denying the leave request);

(i) Employee has a history of leave abuse (obtain copies of payroll leave and attendance records);

(j) Employee has a history of personal or financial problems;

(k) Employee fails to identify witnesses although the injury occurred in an area where it should have been observed;

(l) Witnesses provide incriminating statements;

(m) Employee falsifies or alters forms;

(n) Injury occurs during the first pay period of employment;

(o) Injury occurs when disciplinary action is pending;

(p) Payments were made to physicians without medical reports to substantiate the payments as related to the accepted injury;

(q) Filing of claim is not timely and employee is not sure of data such as date and time of injury. Compare statements of employee, supervisor, witnesses, and treating physician;

(r) Employee changes description of how injury occurred;

(s) Employee has concealed information regarding a previous injury, physical condition, or a medical problem;

(t) Stated disability is inconsistent with the requirements for total disability (look for sprains, cuts, back injuries, and repeated injuries);

(u) Chargeback bill or case file shows little or no medical payments during the billing period, yet employee is on long-term compensation.

c. Actions and Procedures when Fraud or Abuse is Suspected

(1) Identify Suspect Claims. In suspect cases, appropriate officials (a joint effort of the immediate supervisor, safety specialist, and ICPA) should answer the questions in Figure 52 and then determine the proper course of action. Officials should closely scrutinize the claim for possible referral to the agency's investigative service such as Office of Special Investigation, Naval Criminal Investigative Service, or others. Officials should refer only those claims for further action for which there is strong probable cause to believe fraud or abuse is present.

(2) Procedures for Referral to DoD Component Investigative Services

(a) When the ICPA determines that a claim requires internal investigation, he or she prepares a letter for the installation or activity commander's signature (the appropriate requesting authority for investigative services), has it signed, and forwards it to the DoD Component investigative service. The ICPA will retain a copy of the referral request, with any documented evidence, in a separate jacket or file folder (THESE DOCUMENTS WILL NOT BE MAINTAINED IN THE CASE FILE). The request should contain the basis for referral and copies of any relevant documents.

(b) The investigative service shall furnish an original report to the installation or activity commander. Normally, the security police force will be the focal point for receiving, controlling and routing reports of investigation to action offices (commander, base legal, etc.). The ICPA will coordinate with security police to assure access to the reports.

(c) In cases in which preliminary review indicates that additional investigation would be unproductive, the investigative services refer the matter back to the ICPA for any administrative action deemed appropriate. The case may be resubmitted for investigation if changes in the material facts surface.

(d) The ICPA maintains contact with the security police force concerning injury compensation investigations and, at least at quarterly intervals, requests the status of FECA claims under investigation.

(3) Advising OWCP of the Investigation (or Referral). The ICPA should forward the normal claims package to OWCP within the specified time limits. He or she should not delay it because fraud or abuse is suspected and the claim is being referred to or is already under investigation by the investigative services.

(a) In some cases, the preliminary investigation may eliminate suspicions and prove the claim to be legitimate. It is not necessary to routinely advise OWCP of a referral of a claim for investigation.

(b) If it becomes necessary to advise OWCP that a claim is under investigation, the ICPA should do so by separate letter. The letter to OWCP should include a statement such as: "This letter and other information about the agency investigation must be kept in a separate jacket or file folder separate and apart from the claimant's OWCP case file."

(c) The ICPA should ensure that installation records concerning investigations are kept in a locked cabinet or safe, separate and apart from the employees' case files.

9. THIRD-PARTY LIABILITY

a. General Third-Party Liability Information

(1) Purpose. This section deals with on-the-job injuries to DoD employees caused by persons or organizations other than the United States and its agencies.

(2) Objectives of Pursuing Third-Party Claims. The DoD objectives are to ensure that all third-party claims are properly identified before submitting them to OWCP and to ensure that all government funds paid for a job-related injury caused by a third party are recovered to the maximum extent possible.

(3) Background on the Government Subrogation Interest

(a) When the circumstances of the employment-related injury create a legal liability on a third party other than an employee or activity of the Federal Government to pay damages, the Government has a subrogation interest (that is, the right to recover any payments it makes should the claimant collect money or other property in satisfaction of that liability because of a suit or settlement from another source). There are some situations when a Federal employee may be considered a liable third party. For example:

1. Two employees are involved in an altercation while on duty, causing injury to one employee, but the altercation was in no way connected with the performance of duty,

2. While in the performance of duty, an employee's personal auto hits and injures another employee while the latter is driving a car, riding a bicycle, or walking on the activity's premises, or off premises and engaged in the performance of duty.

(b) Third-party claims include injuries caused by individuals and products. For example, if a piece of office furniture, such as a chair, is defective and causes an injury, the manufacturer may be sued. The ICPA or the supervisor should include any information regarding possible third-party claims when submitting claims materials, including the name and address of the third party (person or manufacturer).

(c) While an action or suit is pending against the third party, OWCP shall

provide the full range of medical and compensation benefits authorized by FECA. The employee (or dependents in the case of a fatal injury) may retain 20 percent of the net recovery (the total sum minus the settlement costs) of any third-party settlement. The Government is entitled to any remaining portion to offset the costs of the FECA entitlement. If the amount of FECA benefits paid is greater than the Government's portion of the recovery, the entire remainder is paid directly to OWCP and then credited to the agency through the chargeback system. A surplus exists if the amount of FECA benefits paid is less than the Government's portion of the recovery. Although the employee may keep this surplus, he or she will not be entitled to further FECA benefits until the surplus amount is absorbed. OWCP will resume payment of compensation benefits and medical bills only after the employee has submitted claims equaling the amount ofthe surplus. (Refer to Figure 53 for a sample recovery statement and instructions used by OWCP personnel.)

(d) An employee who sustains a job-related injury cannot recover damages from the United States for the effects of injury through FECA. An employee who refuses to prosecute an action in his or her own name against the responsible third party, after being asked to do so by DOL, may be denied compensation.

b. Third-Party Claim

(1) Identify the Third-Party Claim. Upon receipt of Forms CA-1 or CA-2, the ICPA should review it to decide if a third party was involved. If so, the ICPA should determine whether the third party might be legally responsible for the injury. Examples where a third party may be liable include:

(a) Motor vehicle or aircraft accidents;

(b) Accidents involving tripping, slipping, and falling on sidewalks, steps of non-Federal property (or property leased by the Federal Government);

(c) Accidents involving defective machinery, tools and equipment (includes office-type equipment);

(d) Exposure to asbestos;

(e) Negligence by a contractor or manufacturer.

(2) Actions Required. After identifying a potential third-party claim, the ICPA:

(a) Determines if the employee's supervisor, safety office, security police, local police, or any other organization investigated the incident. If so, obtains a copy of the report and the investigative file;

(b) Includes the following items:

1. A detailed written statement by the injured employee concerning the circumstances of the incident. Also, include statements from witnesses or other persons who may have pertinent information;

2. The name, address, and telephone number of the third party; and,

3. A detailed description of the place where the incident occurred (including a diagram) and all the circumstances concerning the incident;

(c) Upon obtaining the above information, sends the original to OWCP with a copy to the activity's legal representative and to the cognizant supporting DoD liaison; and,

(d) Monitors the progress of DOL's action and obtains periodic status reports from OWCP until the case is closed. Cases closed without payment from the third party (or the employee) should be reported to the servicing liaison.

(3) Prohibitions in Third-Party Cases

(a) Prohibition Contained in FECA. Reference (d) states in part: "No court, insurer, attorney, or other person shall pay or distribute to the beneficiary or his designee the proceeds of such suit or settlement without first satisfying or assuring satisfaction of the interest of the United States."

(b) Advising the Employee. The ICPA should advise the employee that he or she should initiate action to recover damages from the responsible party and that FECA prohibits him or her from accepting the proceeds of a settlement without first satisfying the interest of the United States. Before reaching a settlement, the employee or the employee's representative should contact OWCP. If the claimant does not wish to initiate action to recover the damages, he or she should be encouraged to assign the right to DOL to recover damages.

(4) Referral to Activity Legal Department

(a) When to Refer. If there is an indication that neither the employee nor DOL intends to pursue the third-party aspect of the case, the ICPA should refer the following information to the activity's legal department:

1. Name of the employee;

2. Social Security Number;

3. Date and circumstances of injury;

4. Address of employee;

5. Name and address of third party; and,

6. Dollar amount of expenditures for medical bills, compensation, etc.

(b) Questions to be Resolved. The CPO/HRO should request a response to answer the following questions:

1. Is the third-party liable?

2. Does the activity's legal department agree with the intention not to pursue the

third-party aspect?

3. If the answer to 9.b.(4)(b)2. of this enclosure is negative, what action can be or should be taken to protect the DoD's interest?

(c) Continuation of Pay (COP). COP is not considered compensation; therefore, the cost of COP cannot be recouped in a third-party claim.

10. THE INJURY COMPENSATION CHARGEBACK SYSTEM

a. Itemized Chargeback Listings. The purpose of this section is to provide general information about the DOL chargeback system, coding procedures, the Defense Injury/Unemployment Compensation System (DIUCS), and the Defense Portal Analysis Center (DefPAC). The letters provide guidance for use by ICPA's in validating and verifying the billing lists and monthly statements.

b. The DOL Chargeback System

(1) The Chargeback System Explained. The Chargeback System is the way costs of compensation for work-related injuries and deaths are assigned to employing agencies at the end of the fiscal accounting period, which runs from July to June for chargeback purposes. OWCP furnishes CPMS with a transmittal of payments made for that agency's injured employees. (The term "employee" includes individuals receiving FECA benefits who have been separated from DoD rolls.) CPMS is responsible for loading this transmittal into the DIUCS system, presenting this data to DoD Components in a usable format, providing coding information and assigning chargeback codes to DoD Components.

(2) Chargeback Codes

(a) The chargeback code consists of six characters (four numeric and two alpha). The numeric characters designate the branch of service incurring the charges. The two letter alpha characters designate the servicing CPO/HRO (or reporting office). It is crucial that ICPA's ensure the six character code is annotated on Forms CA-1, Block 17; CA-2, Block 19; and CA-6, Block 6, before sending to OWCP.

(b) The DoD Components will also identify installations or activities with a Unit Identification Code (UIC) and will place this information in the OSHA site code block on Form CA-1, CA-2, etc. EDI will not accept a 9-character entry for the OSHA site code. Therefore leading zeros must be added to any entry with less than nine characters.

(c) To prevent incorrect chargeback codes from appearing on the quarterly chargeback bills, ICPA's should identify coding errors and request corrections as quickly as possible to OWCP through the district liaison (Figure 54).

1. The first opportunity to identify an incorrectly assigned chargeback code occurs on reviewing the Agency Query System, or DIUCS application once electronic notification is received. ICPA's should immediately review these systems and promptly report (in writing) any errors to the DoD servicing liaison who will effect the correction with the

OWCP. If the CPO/HRO does not come forward at this time, OWCP will assume the chargeback code is correct and bill any costs associated with the case to that activity's account. No additional documentation is required if OWCP is immediately notified of the error. If the ICPA fails to find or report the error within 60 calendar days, additional documentation is required to support the request for a change.

2. If an error appears on the quarterly chargeback report, either in DIUCS or DefPAC, and the ICPA can identify the owning activity, the ICPA should confirm ownership with the claimant's employing activity's ICPA. A written request for correction should be forwarded to the supporting DoD liaison with an information copy sent to the owning activity ICPA. The letter should contain a statement that ownership identification had been coordinated with the owning activity ICPA. Disagreements that cannot be resolved will be referred to the supporting DoD liaison for resolution. Disagreements that cannot be resolved with the supporting DoD liaison's assistance will be referred, in writing, to CPMS, Injury Compensation and Unemployment Compensation (ICUC) Division.

3. ICPA's should make every effort to establish the proper chargeback for disputed claims. It may be necessary to send an inquiry to the Federal Records Center and/or request the supporting DoD liaison to review the case file at the OWCP district office (see Figure 55 for sample request).

4. When possible, the ICPA should include the full six character code (four numeric and two alpha) for all changes within the Department of Defense and for changes to other Federal agencies. Requests for changes outside an agency should include proper documentation. For example, include a copy of the SF-50 showing who the claimant worked for at the time of the injury. While there is no need to provide supporting documentation to OWCP when requesting a code change from one activity to another within a DoD Component, activities should ensure that any disagreements in code changes have been resolved within the DoD Component according to paragraph (2) above, before requesting OWCP to make a change.

5. If the evidence establishes that the case belongs to another agency, the OWCP district office will send a copy of the Form CA-1 or Form CA-2 and other appropriate documentation to that agency. If the activity disputes ownership of the case, it will have 60 calendar days to provide evidence before the code is changed.

(d) DoD Injury/Unemployment Compensation System (DIUCS)

1. Provides a standardized and automated approach to managing employee injury and unemployment compensation claims throughout the Department of Defense. The system consists of a centralized database of key personnel, payroll, and DOL case management and payment information about each individual claim filed by DoD employees. Access to the system is through an on-line, menu-driven, graphical user interface providing quick and easy availability of the information stored in the central database. DIUCS consists of a software application known as the Injury Compensation (IC) module. The user can determine the status of a particular claim filed with DOL, identify the number of claims and types of injuries filed, determine what medical payments and compensation have been paid, identify erroneous claims, dual payments and overpayments, produce standard reports, and reconcile DOL chargeback billings.

2. DIUCS gives the user quick and easy access to data through screen and report features using menu bars, icons, buttons, scroll bars, dialogue boxes, status lines, and pop-up windows. The graphical user interface selected for the DIUCS is designed to minimize data entry and provide sufficient on-screen information to make it unnecessary to rely on a printed operational manual for direction or information. Multiple screens are used to display information in a standardized format. Screens can be moved, resized, overlaid and viewed simultaneously. The user creates cases or retrieves information by entering a social security number, date of injury or claim number. System security is maintained through a series of logins, passwords and assignment of access levels. The DIUCS will be maintained in CPOs/HROs and secured at all times.

(3) DOL Chargeback Billing List

(a) The Chargeback Bill Explained. The headquarters office of DOL prepares the chargeback listings. The listings are issued to the activity quarterly and are cumulative for the chargeback fiscal year i.e., July 1 through June 30. The lists include all disbursements or recovery transactions made in the expense period, e.g., the FY93/94 or March 1994 list includes all transactions from July 1, 1993 to March 31, 1994. The fourth quarter listing covers all cases and represents the detail backup to the "chargeback bills" rendered for the full fiscal year. The interim quarterly reports (or listings) provide early notification of cases and payments, allowing early verification and correction before the final bills are issued. Not all the DoD Component ICPA's routinely receive this report, but rely on the DoD Component-specific reports to track costs.

(b) Command Verification and Validation of Cases Listed on the Chargeback Bill. Upon receiving a chargeback bill (see Figure 56), the Command ICPA shall review for accuracy. If a case appears to contain errors, the reporting CPO/HRO is contacted for further information.

(c) Validating the Payments Charged Against the Claim. Figure 56 lists fifteen claimants. A review of the employee case files and queries to the DIUCS reflects the following:

1. Employee A does not send medical bills through the CPO/HRO but expenses appear to be reasonable. Compensation payments are correct;

2. Employee B's medical expenses were submitted through the CPO/HRO and agree with the ICPA's records. However, the claimant has had no dependents after the death of his spouse in May 1993, and it does not appear the rate of compensation has been adjusted to 66 and 2/3 percent. The ICPA had assisted the claimant in preparing notification to OWCP of the death of his spouse. An overpayment exists; therefore, the ICPA must request correction by OWCP, or request supporting DoD liaison assistance in obtaining the change;

3. The new claims indicated by asterisks are compared to those claims in the DIUCS, and all are employees of the activity with the exception of Employee C. A check with civilian personnel records does not show that she is a current or past employee of DASC; however, a further search discloses she is an employee of DeCA serviced by the DASC CPO/HRO. A check of the compensation file indicates an erroneous chargeback code was entered on the Form CA-1. A letter requesting correction is sent to OWCP, via the supporting DoD liaison; or,

4. All of the medical expenses indicated on the chargeback billing list agree with the ICPA's records except those for Employee D who had surgery for her back condition in June. The ICPA forwarded the hospital bills to OWCP but they were not processed by the end of the quarter. A query in DIUCS shows the bills were paid in July and will be reflected on the next chargeback listing.

(d) FECA Monthly Statement, Table 2

1. The Monthly Statement Table 2 Explained. The Monthly Statements are produced by the DOL and provided to CPMS via electronic transmission for verification and audit. They are used by Federal Agencies and the Occupational Safety and Health Agency (OSHA), Office of Federal Agency Programs, to measure rates and injury trends. As new cases are assigned numbers, they are included in the "Table 2" statement as new injuries (or "case creates"). They are then counted against the activity or installation as reportable injuries. Coding errors distort the number of reportable injuries which activities must investigate and report under OSHA reporting requirements and may count against activity goals to reduce the number of new injuries, the number of paid cases, and annual chargeback costs.

2. Verifying and Auditing of Cases Listed. ICPA's should ensure that the monthly report in DIUCS is reviewed for erroneous chargeback codes and other errors using:

a. Guidance provided in sections 10.b.(3)(b) and 10.b.(3)(c) of this enclosure for verifying and validating the DOL chargeback bill;

b. Figure 57, "Sample FECA Monthly Statement with Explanation";

c. Figure 58, "List of Occupational Codes" (these apply only to injuries before 1986);

d. Figure 59, "Nature of Injury Codes";

e. Figure 60 "Anatomical Location of Injury Codes";

f. Figure 61, "Extent of Injury Codes"; and,

g. Figure 62, "Fatal Indicator Code"

(e) Getting the Errors Corrected. Once the ICPA identifies a chargeback coding or cost error, it is his or her responsibility to take immediate action to ensure that it is corrected; and, as applicable, refer to the supporting DoD liaison. As an example, an agency (Agency A) has through April 30 after the end of the last DOL fiscal year (June 30) to transfer costs to another agency (Agency B). Agency A will receive 1 year's credit for the transferred cases and Agency B will be charged for these transferred cases. The Department of Labor will transfer the costs for the previous year only in cases of inter-Component coding errors (e.g., Army to Navy). DOL will not make adjustments to the previous year's chargeback bill for intra-Component coding errors (e.g., Army Corps of Engineers to Army Material Command). Requests made for transfer of costs after April 30 will not be honored that year. Therefore, it is critical that chargeback adjustments be made expeditiously. Sample letters requesting "correction of errors or changes" are at Figures 54

and 55. The Injury Compensation Program expense period runs from July 1 through June 30. Before August 15 of each year, the DOL must provide each agency a statement showing the total cost of benefits made by the DOL for employees or individuals under the jurisdiction of the agency for the preceding expense period. In accordance with reference (a), the data in these statements are to be used by the agency to budget for the next calendar year (EXAMPLE: Injury Compensation costs incurred during the period July 1, 1994, through June 30, 1995, will be budgeted for and paid with FY 97 funds). Payments are due to the DOL within 30 days of fiscal year budget's enactment.

1. (Added)(DAF) The AFPC/ICO should ensure there is a claim file for every case on the chargeback list. If there is no file, the ICS can create one by copying pertinent documents from the OWCP file through ECOMP, or for files not electronically available, request copies directly from OWCP or the supporting DoD liaison.

11. MISCELLANEOUS PROVISIONS

a. Hearings and Review

(1) Rights to Hearing. Reference (a) provides that if a claimant is not satisfied with OWCP's formal decision, he or she is entitled to a hearing with an OWCP representative if:

(a) A reconsideration has not already been requested; or,

(b) The request for the hearing is made within 30 calendar days after the date the decision is issued.

(2) Notice of Hearing. The OWCP Branch of Hearings and Review shall notify the claimant and the servicing activity of the hearing, including the date, time, and place. The notice shall include a statement noting whether an employing agency representative will attend the hearing, and a questionnaire for the ICPA to complete and return to the OWCP.

(3) Role and Responsibility of the ICPA

(a) After receiving notice of the hearing, the ICPA should review each case to decide whether attendance at the hearing is necessary.

(b) If attendance of a representative is warranted, the representative should become thoroughly familiar with the facts and issues involved in the case; review all information related to the case and any other matters pending, such as grievance, arbitration, and Merit System Protection Board actions; and be prepared to testify at the hearing. However, the primary role of the representative is that of an observer without the right to question the claimant or make any argument. The OWCP hearing representative may make a specific request for the employing agency representative to give oral testimony based on the claimant's evidence. The claimant or his or her representative may also cross-examine the employing agency's representative.

(c) If the scheduled OWCP hearing appears to involve a question of legal interpretation of FECA or related legal matter, the employing agency representative should contact the activity's legal services office for assistance or participation at the hearing.

(4) Transcript of Hearing

(a) OWCP will provide a copy of the hearing transcript when the ICPA makes an official request for one. The ICPA may obtain a copy of the transcript by completing the questionnaire attached to the hearing notice or by written request at the hearing.

(b) Upon receipt of the transcript, the ICPA should review the transcript and provide any additional evidence or comments within the 20-day period allowed by DOL (reference (q)).

b. FECA Coverage Under Special Performance of Duty Circumstances

(1) Recreational Injuries

(a) Recreational Injuries Sustained in the Performance of Duty. In general, there are two types of recreation -- formal and informal. Recreational injuries are determined on a case- by-case basis.

1. Formal recreation refers to an organized activity for which an employee is paid or is required to perform as part of training or assigned duties. To be eligible for coverage, the employee must show that the employer materially and clearly benefited from the activity; the employer materially contributed to the activity through donating space, money, or work time; or the employer encouraged participation in the activity.

2. Informal recreation can be illustrated by a group of employees who, while on their lunch hour and on the premises, play catch with a ball or a Frisbee. Coverage ordinarily exists under such informal on-premise circumstances; however, informal recreation off the premises is usually not covered.

(b) Other Recreational Injuries. In some cases, other recreational injuries may be covered. The ICPA should provide answers to applicable questions listed below and any other available pertinent information with the employee's Form CA-1 or Form CA-2.

1. Was the employee's participation voluntary?

2. Was he or she paid for participating?

3. Was the employee ever excused from work to play or practice during scheduled work hours?

4. If the employee refused to participate, would the employee be penalized with respect to security of employment, advancement, or other personnel matters?

5. Was the recreational activity designed for the welfare, convenience, pleasure, or morale of the employee, or to meet a specific need of the employer?

6. What benefit did the employer accrue from the employee's participation?

7. Was the employee encouraged to join the activity? By whom? How?

8. Did the employee's participation in the activity violate any rules or regulations of the employer? If so, these should be explained including the manner in which the rule or regulation was enforced.

9. Did the injury occur during the employee's regular working hours? If no, explain.

10. What leadership, equipment, or facilities did the employer provide for the activity?

11. Was the recreational activity officially sanctioned or sponsored by the employer?

12. What type of funds were used to pay for uniforms and equipment?

13. What control did the employer have over the activity or organization or funds sponsoring the recreational activity?

(2) Idiopathic Falls

(a) Idiopathic Falls Explained. An idiopathic fall is a fall caused by a personal and nonoccupational disease or illness of the employee, such as a heart attack, fainting spell, or epileptic seizure, which is not work-related. The supervisor and ICPA should give special attention to these cases. Injuries caused by such conditions are not covered by FECA, unless there is some intervening employment-related cause. Examples of coverage include:

1. When falling to floor, the employee hit the corner of a desk causing a head injury; or,

2. A firefighter suffered a heart attack and fell to the floor while rescuing an individual from a burning building.

(b) Special Evidence Required. In these type cases, the ICPA obtains appropriate evidence from the employee, the supervisor, witnesses, and all attending physicians. The evidence should show clearly whether the employee fell to the supporting surface (floor); or whether some special condition, hazard or working condition, or factor of employment contributed to or intervened as a cause of the injury. If some factor of the workplace intervened or contributed to the injury resulting from the fall, the employee has coverage for the results of the injury, but not for the idiopathic condition that caused the fall.

(c) Idiopathic Falls Versus Unexplained Falls. A distinction should be made between idiopathic falls and those that are merely unexplained. If a fall cannot be shown to have been caused by an idiopathic condition, but is simply unexplained, it is compensable under FECA if it occurred in the performance of duty.

(3) FECA Coverage While in Official Travel Status. When an employee is on a temporary duty assignment away from his or her regular place of employment, he or she is covered by FECA 24 hours a day with respect to any injury that results from activities essential or incidental to the temporary assignment including securing meals and using lodging facilities. However, when the employee deviates from the normal incidents of his or her trip and engages in activities, personal or otherwise, which are not reasonably incidental to the duties of the temporary assignment, the employee ceases to be under the protection of FECA and any injury occurring during these deviations is not compensable. Employee A on travel status finishes a meeting, returns to the hotel, and hurts her knee while playing basketball with co-workers. An injury such as this would probably not be covered under FECA. Employee B, in travel status, falls in the hotel shower, and is injured; the injury would be covered under FECA. Employee C injured on a sightseeing trip in the city to which she was assigned, would not be covered. Employee D, on a 14-day assignment to another state, travels 150 miles to visit his mother during the weekend. En route, he is severely injured in a car accident. A claim would be denied in this instance because the employee was not engaged in normal activity in the locality indicated by travel orders.

(4) Consequential and Intervening Injuries

(a) Consequential and Intervening Injuries Explained. Under certain circumstances, an injury occurring outside performance of duty may affect the compensability of an already accepted injury. A consequential injury is one that occurs because of weakness or impairment caused by a work-related injury and it may affect the same part of the body as the original injury or a different area altogether. For instance, a claimant with an accepted knee injury may fall at home because the weakened knee has buckled. This incident will constitute a consequential injury whether the affected part of the body is the knee or another area, such as the back or arm;. or a claimant with an injured eye may compensate for loss of functioning by overuse of the other eye that may result in a consequential injury. An injury occurring outside the performance of duty to the same part of the body originally injured is termed an intervening injury if compensation is claimed following the second injury. It must be decided whether the disability is attributable to the second injury alone, or whether the effects of the first injury still contribute to the disability. Unless the second injury breaks the chain of causation between the original injury and the disability claimed, the disability will be considered related to the original incident.

(b) Evidence Required. The employee should explain the details of the second injury and give reasons for believing that second injury is connected to the first. He or she must furnish a medical report on the second injury that includes an opinion concerning the relationship between the two injuries.

c. Coverage for Reserve Officers Training Corps (ROTC) Members. ROTC members are covered under reference (a). Expenses incurred are not billed back to the activity, but paid by separate appropriations to the Fund.

(1) Conditions of Coverage. ROTC members are:

(a) Not covered 24 hours a day;

(b) Not entitled to Continuation of Pay;

(c) Covered because of an injury incurred in the line of duty and only if it is the proximate result of the performance of military training or travel to or from the training;

(d) Covered only during prescribed field training exercise (cadets must actually be participating); and,

(e) Are not covered if injuries occur during nontraining exercises (e.g., recreational time).

(2) Responsibility of the Military Official. Normally, the military official in charge of the ROTC members is responsible for processing claims and counseling cadets. The military official:

(a) Provides a line-of-duty determination citing appropriate statutory authority in support of the determination.

(b) Normally, would not issue a Form CA-16; however, he or she may issue the form. Since issuance of the Form CA-16 obligates the government, the military official should issue the Form CA-16 only when he or she believes the injury was in the performance of duty.

(c) In cases where the military official's opinion shows that the injury was not in the performance of duty, he or she informs the cadet of the cadet's right to file a claim; and,

(d) Informs the cadet that the claim would normally be disallowed by OWCP; and,

1. Filing a claim could cause undue delay in receiving benefits from his or her health insurance carrier; and,

2. Health insurance carriers will not pay benefits until they receive official denial of the claim from OWCP, which normally takes over 3 months. (This could cause financial hardship for the cadet since medical providers will expect payment promptly.)

(3) Special Processing Required. All claims filed by Reserve Officer Training Corp (ROTC) cadets are adjudicated by the Office of Special Claims and are subject to review by the Secretary of Labor. The military official should:

(a) Send claims filed with OWCP by ROTC cadets to: Office of Workers' Compensation Programs, Special Claims – ROTC Case, Room 851, 1240 E. Ninth St, Cleveland, OH 44199; and,

(b) Send Forms CA-1 with no medical expenses and no lost time to the appropriate file custodian at the college or university the cadet is attending for filing as a permanent record in the cadet's official military personnel records.

d. Federal Employees' Health Benefits (FEHB)

(1) Federal Health Benefits Explained. Enrollment of employees, as well as their

surviving beneficiaries, continues when they enter on the OWCP compensation rolls, provided they meet the requirements.

(2) Requirements Employees Must Meet to Continue Enrollment. If a compensation recipient is covered under the Federal Employees' Health Benefits Program at the time of injury, the health benefits coverage will continue as long as compensation is payable. Temporary Continuation of Coverage (TCC) of Health Benefits Insurance is not available to employees who have an entitlement to compensation benefits. Further, it is not available to employees who lose their coverage because their compensation terminates.

(3) Determination of Eligibility. If the employee appears eligible to continue enrollment, show the enrollment code and the ending date of the pay period in which deductions were last made on the Form CA-7. If the employee is not eligible to continue enrollment, note on the Form CA-7 that the employee is "Not eligible to continue health benefits."

(4) Transferring Enrollments to OWCP

(a) Enrollments are transferred to OWCP when one of the following events occurs:

1. OWCP requests the transfer;

2. Ten months of leave without pay have elapsed without OWCP having requested transfer; or,

3. The employee separates before OWCP requests the transfer (see Figures 63 and 64 for Sample Transfer Letters).

(b) A copy of the transfer of health benefits must be forwarded to the servicing payroll office for their files.

(5) Withholdings and Contributions by OWCP

(a) OWCP makes withholdings and contributions regardless of whether the enrollment is transferred to OWCP.

(b) Withholdings and contributions begin the date compensation begins or the date following the date the employing agency's withholdings and contributions ended, whichever is later. EXCEPTION: OWCP does not make withholdings and contributions when the employee receives compensation for fewer than 29 days. In such a case, the employee is responsible for paying his or her share of the enrollment cost and the employing agency is responsible for paying its share.

(6) Transferring the Enrollment Back to the Agency

(a) The enrollment of a claimant who was transferred to OWCP is transferred back to the employing agency when the employee returns to full-time duty and pay status (provided, of course, that the claimant is eligible for continued coverage as an employee).

(b) If the claimant is not eligible for continued coverage as an employee, either OWCP or the employing agency must terminate the enrollment.

(c) If the claimant returns to duty part-time, the enrollment continues with OWCP as long as compensation payments continue. In this case, the individual is receiving both compensation and salary.

(7) Reporting Enrollment to OWCP

(a) When reporting the compensable injury or illness on OWCP Form CA-7, the ICPA must indicate whether the employee was enrolled on the date pay stopped. If the employee was enrolled, the enrollment code and the ending date of the pay period in which insurance withholdings were last made must be shown.

(b) If OWCP determines that the employee will be receiving compensation for at least 6 months, OWCP normally requests the employing agency to transfer the enrollment to OWCP.

(c) If the employee is separated before the employing office receives OWCP's request to transfer the enrollment, the ICPA must check with OWCP to determine the status of the compensation claim. If the compensation is to continue beyond the date of separation, transfer the enrollment to OWCP as explained in paragraph 11.d.(4) of this enclosure.

(d) If an employee makes any permissible change in enrollment before the employing office receives OWCP's request to transfer, the ICPA must notify OWCP by letter of the change and its effective date as soon as the change is received.

(e) If the employee is separated after the enrollment is transferred to OWCP, the ICPA must notify OWCP by letter of the separation so that OWCP will know how to dispose of the enrollment if compensation payments end.

(8) Transferring the Enrollment When Requested by OWCP

(a) The ICPA will make the transfer by attaching all SF-2809s, SF-2810s, and any related health benefits documentation to the request form and returning it to OWCP (see Figure 63.)

(b) The ICPA should keep a copy of the request form in the employee's OPF to show that OWCP has the health benefits documentation.

(c) It is not necessary for the employing agency to complete an SF-2810 transferring the enrollment out. However, when OWCP receives the health benefits documentation, it must complete an SF-2810 transferring the enrollment in to OWCP.

(9) Transferring the Enrollment When Not Requested by OWCP

(a) If the employee is being separated or the employee has been in nonpay status for 10 months and OWCP has not requested that the enrollment be transferred, the ICPA must check with the OWCP to determine the status of the OWCP claim.

(b) If compensation will continue beyond the date of separation or beyond the 365th day of continuous nonpay status, the ICPA must transfer the enrollment to OWCP by sending all SF-2809s and SF-2810s and any other health benefits documentation in the employee's OPF to OWCP by letter (see Figure 64).

(c) It is not necessary for the ICPA to complete an SF-2810 transferring the enrollment out. However, when OWCP receives the documentation, it must complete an SF-2810 transferring the enrollment in to OWCP.

(10) When Compensation Ends and the Employee Returns to Duty

(a) OWCP transfers the enrollment back to the employing agency by letter transmitting the health benefits documentation and giving the date compensation ended.

(b) If the employee's appointment makes him or her eligible for continued coverage, the ICPA completes an SF-2810 transferring the enrollment to the agency. The effective date of the transfer is the day after compensation terminated.

(c) If the employee's appointment does not make him or her eligible for continued coverage, the ICPA completes an SF-2810 terminating the enrollment effective with the date compensation ended. A copy of OWCP's letter transferring the enrollment back to the employing agency must be attached to the carrier copy of the SF-2810.

(d) When an employee returns to duty on a part-time basis and compensation payments continue, OWCP keeps the enrollment and continues to make withholdings and contributions for the employee.

(11) When Compensation Ends but Employee Does Not Return to Duty

(a) If compensation ends, but the employee does not return to pay status, the employee's coverage continues for 365 days after the date compensation terminates.

(b) If the enrollment had been transferred to OWCP, OWCP must transfer the enrollment back to the agency, and the ICPA must complete an SF-2810 transferring the enrollment in.

(c) The employee and the agency are responsible for paying the amount of the withholdings and contributions, just as they are for any other employee in nonpay status.

(12) When Employee Returns to Duty Before Compensation Ends

(a) If an employee returns to duty on a full-time basis before OWCP terminates the compensation payments, the ICPA must notify OWCP by telephone and immediately send a follow-up letter verifying the beginning and ending dates of the pay period in which the employee returns to work. In the remarks section, show the beginning and ending dates of the pay period in

which the employee returns to work.

(b) OWCP will discontinue withholdings and contributions with the beginning date of the pay period in which the employee returns to full-time duty and pay status.

(c) The employing agency must resume withholdings and contributions effective with the first pay period in which the employee returns to pay status

(d) If the enrollment has been transferred to OWCP, OWCP must transfer it back to the agency as described in paragraph 11.d.(10) of this enclosure.

(13) Employee Elects Retirement

(a) If an employee whose enrollment has been transferred to OWCP elects to retire and receive an annuity instead of compensation, the retirement system will ask OWCP to transfer the enrollment to itself.

(b) If the employee is still being carried on the agency rolls in a nonpay status, the employing agency must note on the "Individual Retirement Record" (SF-2806 or SF-3100) under "Remarks," "Health benefits enrollment transferred to OWCP," and send the form to the retirement system as usual

(14) Procedures for Survivors. The enrollment of a deceased employee continues for the surviving family members if the deceased employee was enrolled for self and family at the time of death and at least one of the covered family members must receive compensation as a surviving beneficiary under the Federal Employees' Compensation law.

(15) If the Enrollment Was Not Transferred to OWCP

(a) If an enrolled employee dies and the enrollment has not been transferred to OWCP, the employing agency must determine whether there is a surviving family member who appears eligible to continue the enrollment.

(b) If there appears to be no eligible survivor, the agency terminates the enrollment.

(c) If a survivor appears eligible for continued coverage, the agency sends the health benefits documentation to the retirement system in the same way as for any other death-in-service case. If the survivor elects to receive compensation rather than survivor benefits, the retirement system will transfer the enrollment to OWCP.

(16) If the Enrollment Was Transferred to OWCP

(a) If an enrolled employee dies and the enrollment has been transferred to OWCP, the employing agency must note on the employee's Individual Retirement Record (SF-2806 or SF-3100) in "Remarks" "Health benefits transferred to OWCP," and send the form to the retirement system as usual.

(b) OWCP determines whether there are survivors who are eligible and who want to continue the enrollment. If the survivors elect to continue to receive compensation, OWCP continues or terminates the enrollment as appropriate. If the survivors elect to receive survivor benefits instead of compensation, OWCP transfers the enrollment to the retirement system.

e. Federal Employees' Group Life Insurance (FEGLI)

(1) When an Employee is on Continuation of Pay (COP). No action needs to be taken on FEGLI; coverage, withholding, and contributions continue.

(2) When an Employee is on Leave Without Pay (LWOP). Withholdings for basic life insurance, Accidental Death and Dismemberment (AD&D), and optional life insurance begin as soon as the employee begins receiving compensation, even if it is within the first 12 months of nonpay status. The only exception occurs when an employee receives compensation for fewer than 29 days. In such cases, OWCP makes no withholdings or contributions; the employee and agency share the cost of enrollment. Form CA-7 is used to notify OWCP of optional insurance coverage and changes in basic pay that occur so that premium withholdings can be adjusted.

(3) When an Employee Returns to a Light Duty Job. Enrollment is transferred back to the employing agency. If the employee has a loss of wages due to the partial disability, premiums will be based on the amount earned in the light duty position rather than the salary at the time of injury.

(4) When FEGLI Coverage Must Terminate. When FEGLI coverage as an employee must terminate because of completion of 12-months nonpay status and the employee is:

(a) Not eligible to, or does not wish to, continue coverage as a claimant, the employing office terminates the enrollment in the same manner as any other employee in a nonpay status. To be eligible to continue FEGLI coverage after separation or 12 months of nonpay status, the employee must have been enrolled since his or her first opportunity or for 5 years immediately preceding the start of compensation; or,

(b) Be eligible and wishes to continue basic and optional coverage as a claimant, the employing office would:

1. Provide the employee a SF-2819, "Notice of Conversion Privilege";

2. Complete a SF-2821, "Agency Certification of Insurance Status";

3. Have the employee complete a SF-2818, "Continuation of Life Insurance Coverage as a Retiree or Compensationer"; and,

4. Attach SF-2818, all designations of beneficiary, and all life insurance elections to SF-2821 (Part 1) and send to OPM.

f. Transfer of Function

(1) Transfer of Function Explained. If an agency or instrumentality (or part or function thereof) is transferred to another agency or instrumentality, the cost of compensation benefits and other expenses paid on account of the injury or death of employees of the transferred function is assumed by the gaining agency. The losing agency coordinates the transfer of function with the gaining agency.

(2) Notifying OWCP of the Transfer. In order that costs be appropriately charged to the gaining agency or instrumentality, OWCP must be advised of the transfer of function and of the cases to be transferred to the gaining activity.

(a) The notification letter must contain the following information:

1. Effective date of the transfer;

2. Losing and gaining activity identified by name;

3. Losing chargeback code (six characters) and gaining chargeback code;

4. Address for the new servicing CPO/HRO;

5. Name and telephone number of a point of contact at losing and gaining activities;

6. Listing of claims to be transferred which includes case number, name, social security number, and date of injury.

(b) An information copy of the notification and listing should be provided to the gaining activity.

(c) The appropriate supporting DoD liaisons will effect the changes in chargeback codes at the district office(s). Refer to Figure 54 for sample letter notifying the liaison of transfer of function and claims.

(3) Official Notification to the Gaining Activity. After OWCP has received the transfer of function information from the supporting DoD liaison, it will provide the names of the claimants affected by the transfer of function to the gaining activity. The gaining activity has 60 days to raise issues of case ownership.

(4) When Charges are Included in Chargeback Billing. Charges to the gaining activity's chargeback account include all costs incurred during the OWCP billing period (July 1 through June 30) in which the transfer took place. This includes transfers effective on the last day of the billing period, June 30.

(5) Transfer of Activity Case Files. The gaining activity must have comprehensive case records of the transferred claimants to exercise effective case management. Before shipping the case files to the gaining agency, the losing activity should screen case files to assure information critical to good case management is in the file.

(6) Restoration Rights When Function is Transferred. If an employee is out of work due to compensable injury, and his or her function is transferred to another agency to which the employee would have been transferred had he or she been present, the employee has restoration rights to the gaining agency. The losing agency should notify the employee of the transfer and the location at which to apply for restoration. If the employee would not have been transferred with the function, he or she has restoration rights to the former agency.

(7) Management of Closed Installation Injury Cases. Each DoD Component or DoD Component's major command will assign the injury cases of a closed installation to a successor CPO/HRO within the same component.

(a) The designated successor manager should be located, whenever possible, in the same OWCP District Office as the closed installation. Typically, case files, injury case management resources, and, depending on DoD Component FECA bill payment policy, the dollars required to pay for the end of the chargeback year costs associated with the cases will be transferred to the successor manager.

(b) Exceptions to 11.f.(7)(a) of this enclosure may be made when fiscally and managerially appropriate. The supporting DoD liaison will be informed of any such exception.

g. Reduction in Force (RIF) Situations

(1) Impact of RIF on Employees on the Compensation Rolls. An employee who is on the compensation rolls is subject to reduction in force just like other agency employees and is entitled to whatever rights he or she would have to another job had the injury not occurred. Separation by RIF or for cause while on compensation terminates entitlement to credit for the subsequent period the employee continues to receive compensation and also means the individual has no restoration rights.

(2) Impact of RIF on Reemployed Claimants. Reemployed claimants sometimes face removal from employment due to a RIF or the closing of an installation. The status of such employees with respect to receipt of further compensation benefits differs according to whether a formal LWEC determination has been made.

(a) When a formal LWEC has been determined and a Form CA-1048 or CA-1047 has been issued by OWCP, the claimant has the burden, with respect to any subsequent loss of earnings, to show that one of the accepted reasons for modifying an LWEC applies. These reasons are:

1. The original LWEC rating was in error;

2. The employee's medical condition has changed; or,

3. The employee has been vocationally rehabilitated, either through vocational training or self-rehabilitation, and his or her wage-earning capacity has increased as a result. Therefore, the status of an employee with an established wage-earning capacity who is removed because of a RIF does not change regarding receipt of FECA benefits.

(b) When no formal finding concerning wage-earning capacity has been made, and

the claimant has worked in the position for at least 60 days, OWCP may consider a retroactive LWEC determination. This is true even though the claimant is a Federal employee, since general availability of the job need not be considered for a position actually held.

(c) If a retroactive LWEC determination cannot be made:

1. The claimant files a Form CA-7 and is reinstated to temporary total disability until a second opinion medical examination establishes if there is a continuing injury-related disability.

2. If no continuing injury-related disability is established, compensation is terminated.

3. If injury-related disability is established, the claimant is placed on the periodic roll and if appropriate, referred to rehabilitation services. The claimant receives compensation on the basis of temporary total disability until his or her wage-earning capacity can be determined.

h. Voluntary Separation Incentive Program (VSIP)

(1) In instances where an employing agency has offered separation pay ("buyout"), compensation must be suspended until such time that the number of weeks of compensation is equal to the total gross sum of the VSIP payment. EXAMPLE: The amount of the VSIP is $25,000. If 70 weeks of compensation is equal to $25,000, the employee does not have entitlement to compensation for 70 weeks.

(2) The combination of compensation pay and separation pay constitutes dual benefits; the two cannot be received concurrently. It is MANDATORY that when an employee receiving compensation benefits applies and is approved for a "buyout," the ICPA forwards a copy of the SF-50 to the supporting DoD liaison and to the OWCP district office, indicating the amount of the "buyout" and effective date of separation.

12. (Added)(DAF) FEDERAL EMPLOYEES' COMPENSATION ACT (FECA) WORKING GROUP (WG)

a. (Added)(DAF) Purpose and Structure.

(1) (Added)(DAF) A FECA WG should analyze costs, lost days, trends and plans, and develop cost containment initiatives to reduce new lost-time compensable injuries and the number of COP days. The WG also should assist in return to work efforts for civilians with job-related injuries and illnesses as a means of reducing overall costs allocated to work-related injuries.

(2) (Added)(DAF) The base commander or his or her designee serves as chair of the WG. (T-0). The WG members consist of commanders and directors of organizations, including tenants, representatives from the installation's safety, medical, and legal staff, a CPS staff member, investigative staff (if applicable), a representative of the servicing legal office, and other staff as appropriate. Base commanders have the option of creating one

WG for the entire base and include all tenants, or each tenant has the option of creating a WG within their organization. AFPC/ICO will provide each WG with data regarding the operating status of the base's injury compensation program and will attend via teleconference upon request of the WG chair.

Appendix

Figures

APPENDIX TO ENCLOSURE 3

FIGURES

Figure 5. Form CA-11, "When Injured at Work Information Guide for Federal Employees"

Division of Federal Employees' Compensation - CA-11 When Injured at Work Information Guide for Federal Employees

U.S. Department of Labor
Employment Standards Administration
Division of Federal Employees' Compensation

www.dol.gov/esa

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CA-11 When Injured at Work Information Guide for Federal Employees

Compliance Assistance
OWCP
DFEC
About DFEC
DFEC Contacts
DFEC Customer Assistance
DFEC Smallpox Policy Statement

Introduction

The Federal Employees' Compensation Act (FECA) (5 U.S.C. 8101 et seq.) is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor. It provides compensation benefits to civilian employees of the United States for disability due to personal injury sustained while in the performance of duty or to employment-related disease. The FECA also provides for the payment of benefits to dependents if the injury or disease causes the employee's death. Benefits cannot be paid if the injury or death is caused by the willful misconduct of the employee or by the employee's intention to bring about his or her injury or death or that of another, or if intoxication (by alcohol or drugs) is the proximate cause of the injury or death.

Medical Benefits

An employee is entitled to medical, surgical and hospital services and supplies needed for treatment of an injury as well as transportation for obtaining care. The injured employee has initial choice of physician and may select any qualified local physician or hospital to provide necessary treatment or may use agency medical facilities if available. Except for referral by the attending physician, any change in treating physician after the initial choice must be authorized by OWCP. Otherwise, OWCP will not be liable for the expenses of treatment.

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. If the physician selected has been excluded from participating in the Compensation Program the OWCP District Office will advise the employee of the exclusion and the need to select another physician.

Compensation for Temporary Total Disability

An employee who sustains a disabling, job-related traumatic injury may request continuation of regular pay for the period of disability not to exceed 45 calendar days or sick or annual leave. If disability continues beyond 45 days or the employee is not entitled to continuation of pay, the employee may use sick or annual leave or enter a leave without pay status and claim compensation from OWCP.

When disability results from an occupational disease, the employing agency is not authorized to continue the employee's pay. The employee may use sick or annual leave or enter a leave without pay status and claim compensation.

Compensation for loss of wages may not be paid until after a three-day waiting period, except when permanent effects result from the injury or where the disability causing wage loss exceeds 14 calendar days. Compensation is generally paid at the rate of 2/3 of the salary if the employee has no dependents and 3/4 of the salary if one or more dependents are claimed.

The term "dependent" includes a husband, wife, unmarried child under 18 years of age, and a wholly dependent parent. An unmarried child may qualify as a dependent after reaching the age of 18 if incapable of self-support by reason of mental or physical disability, or as long as the child continues to be a full-time student at an accredited institution, until he or she reaches the age of 23 or has completed four years of education beyond the high school level.

Compensation for Permanent Effects of Injury

The Act provides a schedule of benefits for permanent impairment of certain members, functions and organs of the body such as the eye, arm, or kidney and for serious disfigurement of the head, face or neck. For example, an award of 160 weeks of compensation is payable for total loss of vision in one eye.

In addition, compensation for loss of earning capacity may be paid if the employee is unable to resume regular work because of injury-related disability. This compensation is paid on the basis of the difference between the employee's capacity to earn wages after an injury and the wages of the job he or she held when injured.

file:///P|/ICUC/SC810-14Jul05/SC810F5_810-5.htm (1 of 3)7/27/2005 8:10:14 AM

Figure 5. Form CA-11, "When Injured at Work Information Guide for Federal Employees," Continued

OWCP may arrange for vocational rehabilitation and provide a maintenance allowance not to exceed $200 per month. A disabled employee participating in an OWCP-approved training or vocational rehabilitation program is paid at the compensation rate for total disability.

If the employee's condition requires a constant attendant, an additional amount not to exceed $1500 per month may be allowed.

Compensation for Death

If no child is eligible for benefits, the widow or widower's compensation is 50 percent of the employee's pay at the time of death, if death was due to the employment-related injury or disease. If a child or children are eligible for benefits, the widow or widower is entitled to 45 percent of the pay and each child is entitled to 15 percent. If children are the sole survivors, 40 percent is paid for the first child and 15 percent for each additional child, to be shared equally. Other persons such as dependent parents, brothers, sisters, grandparents, and grandchildren may also be entitled to benefits. The total compensation may not exceed 75 percent of the employee's pay or the pay of the highest step for GS-15 of the General Schedule, except when such excess is created by authorized cost-of-living increases.

Compensation to an employee's surviving spouse terminates upon his or her death or remarriage. A widow or widower's benefits continue, however, if the remarriage takes place after the age of 55. Awards to children, brothers, sisters and grandchildren terminate at the age of 18, unless the dependent is incapable of self-support, or continues to be a full-time student at an accredited institution, until he or she reaches the age of 23, or has completed four years of education beyond the high school level.

Burial expenses not to exceed $800 are payable. Transportation of the body to the employee's former residence in the United States is provided where death occurs away from the employee's home station. In addition to any burial expenses or transportation costs, a $200 allowance is paid for the administrative costs of terminating an employee's status with the Federal Government.

Cost-of-Living Increases

Compensation payments on account of a disability or death which occurred more than one year before March 1 of each year, are increased on that date by any percentage change in the Consumer Price Index published for December of the preceding year.

Settlements With Third Parties

Where an employee's injury or death in the performance of duty occurs under circumstances placing a legal liability on a party other than the United States, a portion of the cost of compensation and other benefits paid by OWCP must be refunded from any settlement obtained. OWCP will assist in obtaining the settlement and the Act guarantees that the employee may retain a certain proportion of the settlement (after any attorney fees and costs are deducted) even when the cost of compensation and other benefits exceeds the amount of the settlement.

Appeal Rights

An employee or survivor who disagrees with a final determination of OWCP may request an oral hearing or a review of the written record from the Branch of Hearings and Review. Oral and/or written evidence in further support of the claim may be presented. The employee may also request a reconsideration of a decision by submitting a written request to the District Office which issued the decision. The request must be accompanied by evidence not previously submitted. If reconsideration has been requested, a hearing on the same issue may not be granted. The employee or survivor may also request review by the Employees' Compensation Appeals Board (ECAB). Because the ECAB rules solely on the evidence of record at the time the decision was issued, no additional evidence may be presented.

More Detailed Information

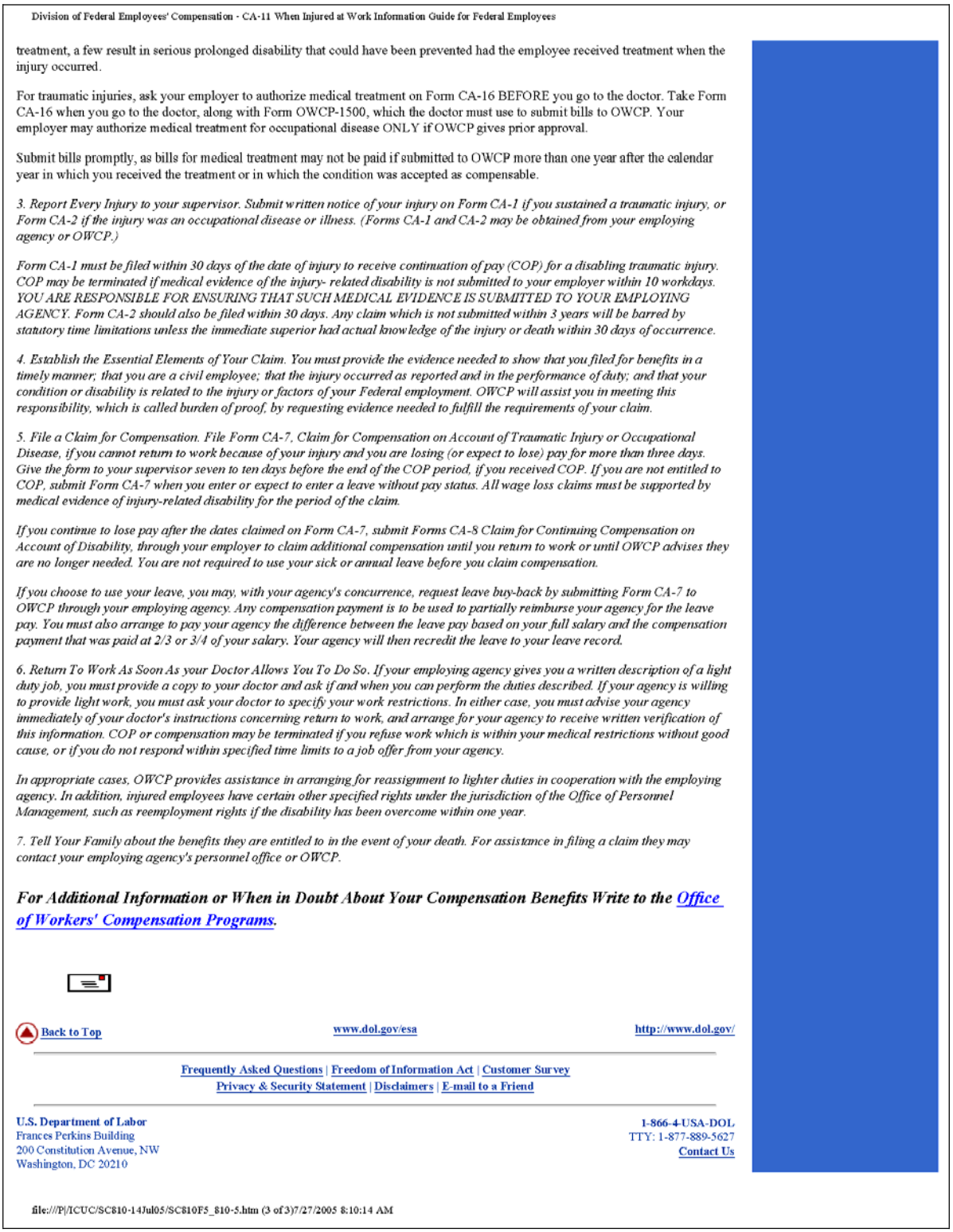
More detailed information about the requirements for coverage and benefits under the Federal Employees' Compensation Act may be obtained from Federal Personnel Manual Chapter 810, Injury Compensation [now OWCP Publication CA-810], and booklet CA-550, Questions and Answers About the Federal Employees' Compensation Act, which answers questions commonly asked about compensation benefits.

What To Do...

1. Keep This Pamphlet. It is important that you know what you are entitled to, since benefits are not paid automatically. You or your survivors must claim them.

2. In Case of Injury, obtain first aid or medical treatment even if the injury is minor. While many minor injuries heal without

Figure 5. Form CA-11, "When Injured at Work Information Guide for Federal Employees," Continued



treatment, a few result in serious prolonged disability that could have been prevented had the employee received treatment when the injury occurred.

For traumatic injuries, ask your employer to authorize medical treatment on Form CA-16 BEFORE you go to the doctor. Take Form CA-16 when you go to the doctor, along with Form OWCP-1500, which the doctor must use to submit bills to OWCP. Your employer may authorize medical treatment for occupational disease ONLY if OWCP gives prior approval.

Submit bills promptly, as bills for medical treatment may not be paid if submitted to OWCP more than one year after the calendar year in which you received the treatment or in which the condition was accepted as compensable.

3. Report Every Injury to your supervisor. Submit written notice of your injury on Form CA-1 if you sustained a traumatic injury, or Form CA-2 if the injury was an occupational disease or illness. (Forms CA-1 and CA-2 may be obtained from your employing agency or OWCP.)

Form CA-1 must be filed within 30 days of the date of injury to receive continuation of pay (COP) for a disabling traumatic injury. COP may be terminated if medical evidence of the injury- related disability is not submitted to your employer within 10 workdays. YOU ARE RESPONSIBLE FOR ENSURING THAT SUCH MEDICAL EVIDENCE IS SUBMITTED TO YOUR EMPLOYING AGENCY. Form CA-2 should also be filed within 30 days. Any claim which is not submitted within 3 years will be barred by statutory time limitations unless the immediate superior had actual knowledge of the injury or death within 30 days of occurrence.

4. Establish the Essential Elements of Your Claim. You must provide the evidence needed to show that you filed for benefits in a timely manner; that you are a civil employee; that the injury occurred as reported and in the performance of duty; and that your condition or disability is related to the injury or factors of your Federal employment. OWCP will assist you in meeting this responsibility, which is called burden of proof, by requesting evidence needed to fulfill the requirements of your claim.

5. File a Claim for Compensation. File Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease, if you cannot return to work because of your injury and you are losing (or expect to lose) pay for more than three days. Give the form to your supervisor seven to ten days before the end of the COP period, if you received COP. If you are not entitled to COP, submit Form CA-7 when you enter or expect to enter a leave without pay status. All wage loss claims must be supported by medical evidence of injury-related disability for the period of the claim.

If you continue to lose pay after the dates claimed on Form CA-7, submit Forms CA-8 Claim for Continuing Compensation on Account of Disability, through your employer to claim additional compensation until you return to work or until OWCP advises they are no longer needed. You are not required to use your sick or annual leave before you claim compensation.

If you choose to use your leave, you may, with your agency's concurrence, request leave buy-back by submitting Form CA-7 to OWCP through your employing agency. Any compensation payment is to be used to partially reimburse your agency for the leave pay. You must also arrange to pay your agency the difference between the leave pay based on your full salary and the compensation payment that was paid at 2/3 or 3/4 of your salary. Your agency will then recredit the leave to your leave record.

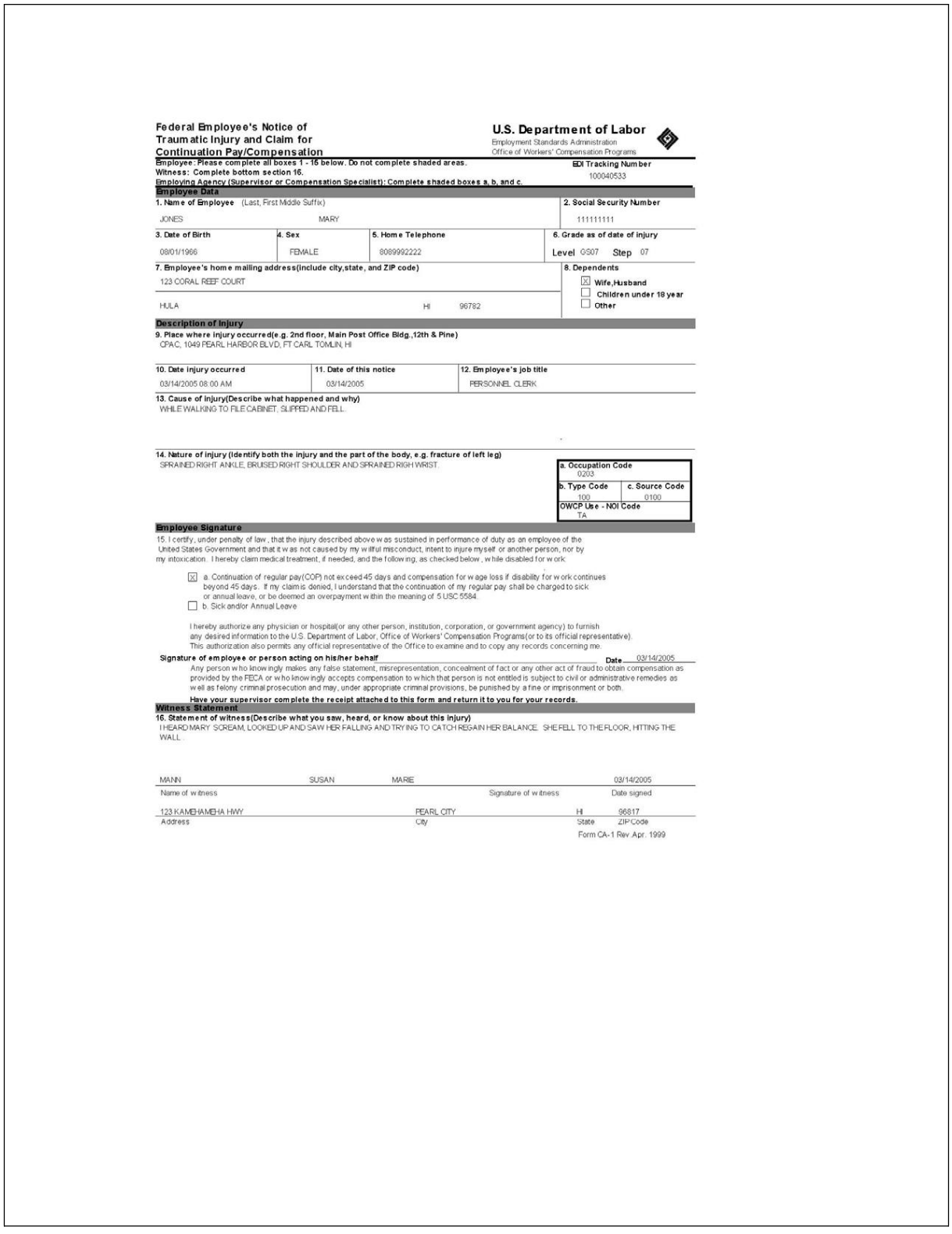
6. Return To Work As Soon As your Doctor Allows You To Do So. If your employing agency gives you a written description of a light duty job, you must provide a copy to your doctor and ask if and when you can perform the duties described. If your agency is willing to provide light work, you must ask your doctor to specify your work restrictions. In either case, you must advise your agency immediately of your doctor's instructions concerning return to work, and arrange for your agency to receive written verification of this information. COP or compensation may be terminated if you refuse work which is within your medical restrictions without good cause, or if you do not respond within specified time limits to a job offer from your agency.

In appropriate cases, OWCP provides assistance in arranging for reassignment to lighter duties in cooperation with the employing agency. In addition, injured employees have certain other specified rights under the jurisdiction of the Office of Personnel Management, such as reemployment rights if the disability has been overcome within one year.

7. Tell Your Family about the benefits they are entitled to in the event of your death. For assistance in filing a claim they may contact your employing agency's personnel office or OWCP.

For Additional Information or When in Doubt About Your Compensation Benefits Write to the Office of Workers' Compensation Programs.

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions



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

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.

EDI Tracking Number: 100040533

Employee Data

1. Name of Employee (Last, First Middle Suffix)		2. Social Security Number
JONES	MARY	111111111

3. Date of Birth	4. Sex	5. Home Telephone	6. Grade as of date of injury
08/01/1966	FEMALE	8089992222	Level GS07 Step 07

7. Employee's home mailing address(include city,state, and ZIP code)
123 CORAL REEF COURT
HULA HI 96792

8. Dependents
[X] Wife,Husband
[ ] Children under 18 year
[ ] Other

Description of Injury

9. Place where injury occurred(e.g. 2nd floor, Main Post Office Bldg.,12th & Pine)
CPAC, 1049 PEARL HARBOR BLVD, FT CARL TOMLIN, HI

10. Date injury occurred	11. Date of this notice	12. Employee's job title
03/14/2005 08:00 AM	03/14/2005	PERSONNEL CLERK

13. Cause of injury(Describe what happened and why)
WHILE WALKING TO FILE CABINET, SLIPPED AND FELL.

14. Nature of injury (Identify both the injury and the part of the body, e.g. fracture of left leg)
SPRAINED RIGHT ANKLE, BRUISED RIGHT SHOULDER AND SPRAINED RIGH WRIST.

a. Occupation Code: 0203
b. Type Code: 100
c. Source Code: 0100
OWCP Use - NOI Code: TA

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:

[X] a. Continuation of regular pay(COP) not 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 03/14/2005

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)
I HEARD MARY SCREAM, LOOKED UP AND SAW HER FALLING AND TRYING TO CATCH REGAIN HER BALANCE. SHE FELL TO THE FLOOR, HITTING THE WALL.

MANN	SUSAN	MARIE		03/14/2005
Name of witness			Signature of witness	Date signed

123 KAMEHAMEHA HWY	PEARL CITY	HI	96817
Address	City	State	ZIP Code

Form CA-1 Rev. Apr. 1999

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

Official Supervisors Report. Please complete information requested below:

Supervisors Report

17. Agency name and address of reporting office(include city, state, and ZIP code)
US ARMY AFSC 3119 DIAMOND HEAD ROAD
FT CARL TOMLIN HI 96816
OWCP Agency Code 9999 00
OSHA Site Code 000253142

18. Employee's duty station(Street address and ZIP code)
HR OFFICE
FT CARL TOMLIN HI 96816
Zip Code

19. Employee's retirement coverage [X] CSRS [ ] FERS [ ] Other, (identify)

20. Regualr work hours From: 08:00 AM To: 04:00 PM
21. Regular work schedule [ ] Sun [X] Mon [X] Tue [X] Wed [X] Thu [X] Fri [ ] Sat

22. Date of injury 03/14/2005
23. Date notice received 03/14/2005
24. Date stopped work 03/14/2005 10:00 AM
25. Date pay stopped
26. Date 45 day period began 03/15/2005
27. Date returned to work 03/17/2005 08:00 AM

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

29. Was injury caused by employees willful misconduct, intoxication, or intent to injure self or another? [ ] Yes (If "Yes", explain) [X] No

30. Was injury caused by third party? [ ] Yes [X] 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)
USA HEALTH CLINIC
2708 BATAN DRIVE
FT CARL TOMLIN HI 96816
33. First date medical care received 03/14/2005
34. Do medical reports show employee is disabled for work? [X] Yes [ ] No

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

36. If the employing agency controverts continuation of pay, state reason in detail.
37. Pay rate when employee stopped work $10.66 Per HOUR

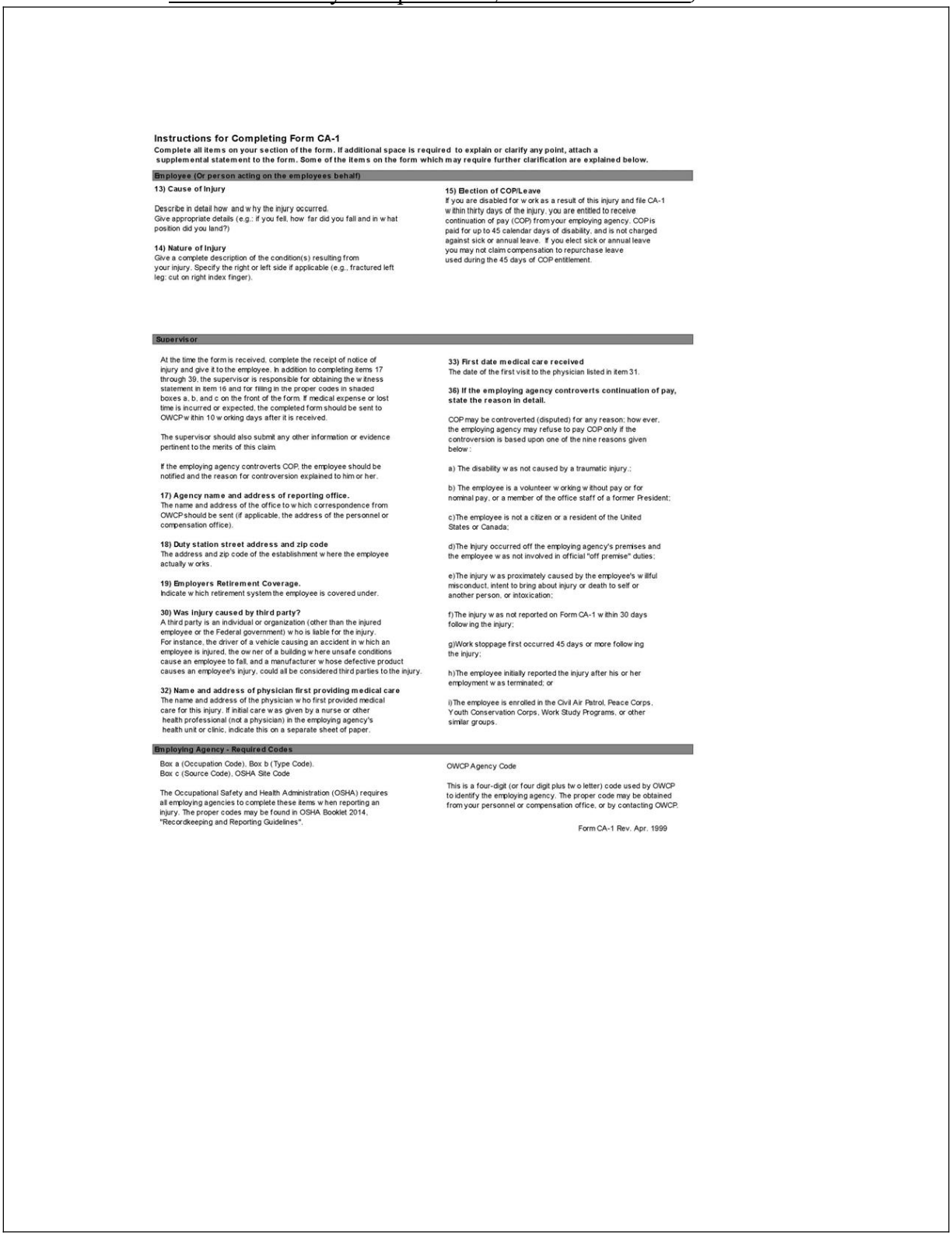
Signature of Supervisor and Filing Instructic

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:

WILSON MARY
Name of Supervisor (Type or Print)
03/17/2005
Signature of Supervisor Date
HR SPECIALIST 8089992230
Supervisor's Title Office Phone

39. Filing instructions
[X] No lost time and no medical expense: Place this form in employers medical folder(SF-65-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

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued



Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

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

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office.

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

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

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury.;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c)The employee is not a citizen or a resident of the United States or Canada;

d)The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e)The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f)The injury was not reported on Form CA-1 within 30 days following the injury;

g)Work stoppage first occurred 45 days or more following the injury;

h)The employee initially reported the injury after his or her employment was terminated; or

i)The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code). Box c (Source Code), OSHA Site Code

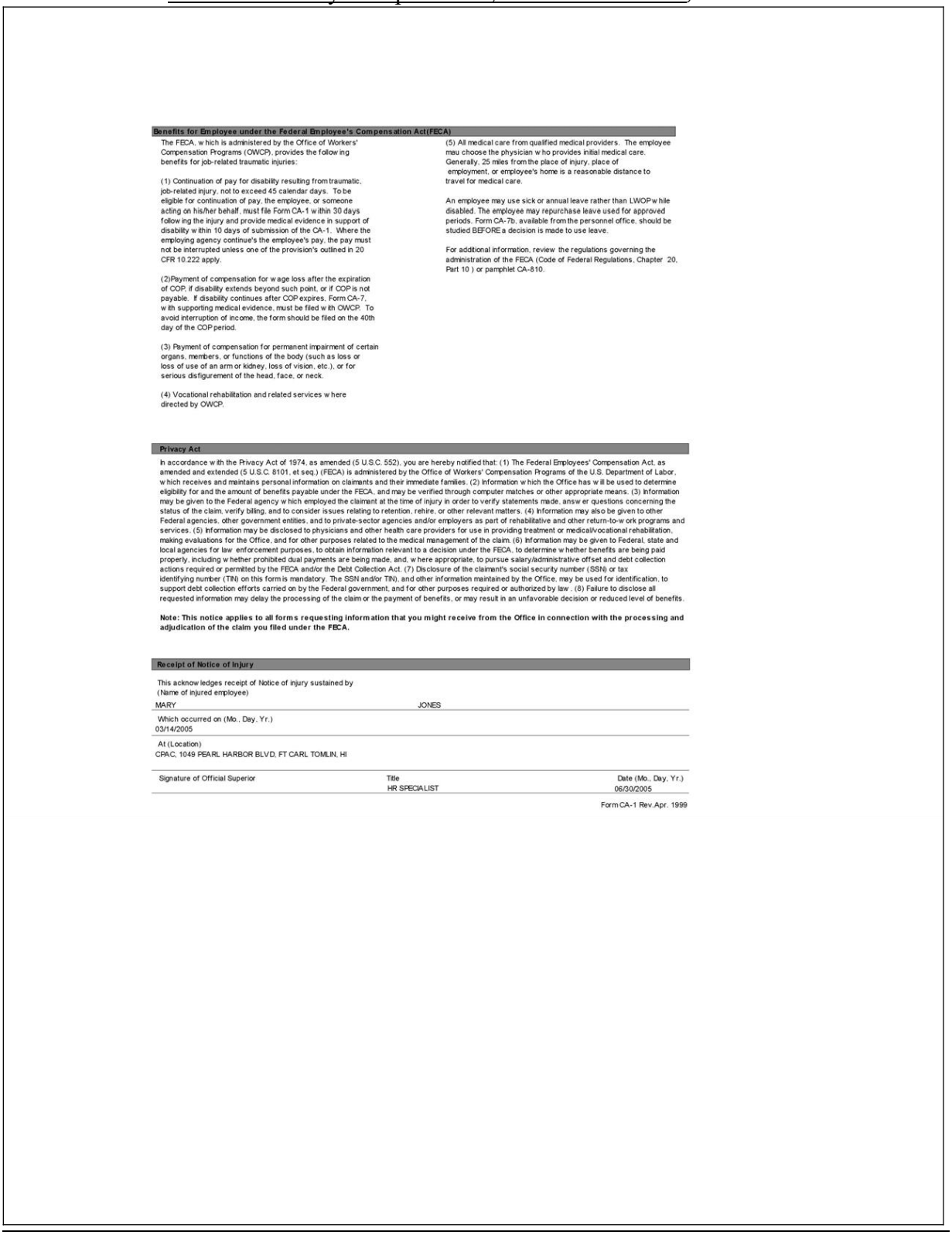
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines".

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-1 Rev. Apr. 1999

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued



Benefits for Employee under the Federal Employee's Compensation Act(FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2)Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.

(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 directed by OWCP.

(5) All medical care from qualified medical providers. The employee mau choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

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 office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552), 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 Injury

This acknowledges receipt of Notice of injury sustained by
(Name of injured employee)

MARY JONES

Which occurred on (Mo., Day, Yr.)
03/14/2005

At (Location)
CPAC, 1049 PEARL HARBOR BLVD, FT CARL TOMLIN, HI

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
	HR SPECIALIST	06/30/2005

Form CA-1 Rev.Apr. 1999

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

EMPLOYEE RIGHTS AND RESPONSIBILITIES WHEN INJURED AT WORK

It has come to our attention that you have been involved in a work-related accident. We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA) should you file a workers' compensation claim.

The Office of Workers' Compensation Programs (OWCP) administers the FECA and has sole adjudication authority for federal workers' compensation claims. The ICPA office, in conjunction with the Civilian Personnel Management Service, Injury & Unemployment Compensation Division, is responsible for monitoring your entitlement to the benefits outlined within the FECA and administered by the OWCP.

FILING A WORKERS' COMPENSATION CLAIM

If you voluntarily elect to file a workers' compensation claim in relation to the reported accident, please complete the on-line OWCP Form CA-1 or CA-2 with your supervisor.

Form CA-1, Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation may be completed to report a traumatic injury, which is an injury that has occurred within one tour of your regular duty. Form CA-1 should be filed within 30 days of the injury.

Form CA-2, Notice of Occupational Disease and Claim for Compensation, may be completed to report an occupational disease, which is an injury or illness that has developed over a period greater than one tour of official duty. Form CA-2 should be filed within 30 days of the date you realized the disease or illness was caused or aggravated by the employment.

When filing a claim for Occupational Disease or Illness, you must submit the specific detailed information described on Form CA-2 and on any checklist (Form CA-35, A-H) provided by your supervisor or the human resources office. OWCP has developed these checklists to address particular occupational diseases. Medical reports must also include the information specified on the checklist for the particular disease claimed.

Once a claim has been filed with the OWCP, you have the right to withdraw your workers' compensation claim, (but not the notice of injury) by so requesting in writing to OWCP through your responsible ICPA office at any time before OWCP determines eligibility for benefits.

OBTAINING MEDICAL TREATMENT

You have a right to choose your treating physician. You must notify your supervisor of your preferred choice prior to scheduling an appointment. Any request by your supervisor or the occupational health clinic to be evaluated by medical clinic or contract physician must not interfere with your preferred physician appointment.

When an appointment with your preferred physician is requested for a traumatic injury, your supervisor may complete the front of Form CA-16, "Authorization for Examination and/or Treatment". In an emergency, where there is no time to complete the form, the ICPA office may authorize medical treatment by telephone and then forward Form CA-16 to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is not allowed under any other circumstance. Your supervisor, or the ICPA office may refuse to issue a CA-16 if more than 48 hours has elapsed since the injury occurred, or the treatment is based on an Occupational Disease or Illness.

If you require medical treatment because of a work-related occupational illness, it is recommended that you obtain care directly from a physician, preferably from a specialist in the indicated field. If OWCP accepts the claim, medical treatment required by the condition(s) accepted, including treatment received before acceptance may be reimbursed to you or your health insurance carrier by the OWCP after adjudication. Form CA-16 may not be used to authorize treatment for occupational disease or illness except in very unusual situations.

For each type of claim, you are responsible for submitting, or arranging for submittal of a medical report from the treating physician for every medical service provided to you resulting from the job-related injury. You must also submit medical evidence showing that the condition claimed is disabling when applying for wage loss benefits.

Medical reports from service providers must include the following:

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

- Dates of examination and treatment
- History given by you
- Physical findings
- Results of diagnostic tests
- Diagnosis
- A description of any other conditions found but not due to the claimed injury;
- Treatment provided or recommended for the claimed injury
- Physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;
- Extent of disability affecting your ability to work due to the injury;
- Prognosis for recovery; and
- Work limitations

MEDICAL BILL PAYMENTS

Your provider has the option of sending bills for injury-related treatment or services electronically, or in paper form. Providers that elect to submit bills electronically must enroll as a DOL provider by completing the Provider Enrollment Form at the following web address:
https://owcp.dol.acs-inc.com/portal/pdf/Provider_Enrollment_Form_Final.pdf

OWCP will pay appropriate charges for medical treatment if your case is approved and the treatment was necessary for the job-related injury. OWCP applies a schedule of maximum allowable medical charges to pay work-related bills submitted by a provider of service. OWCP will only authorize payment of treatment or services that are related to an accepted work-related condition.

You are not responsible for paying the difference between the maximum charge set by the schedule for a particular treatment and the charge made by the provider for bills submitted on an OWCP accepted claim. You are, however, responsible for payment of medical bills resulting from an occupational disease or illness until a claim is accepted by the OWCP.

You may be reimbursed for employee-paid medical, surgical, and dental services using Form **HCFA-1500, American Medical Association Standard Health Insurance Claim Form**, or **OWCP-1500**, the version of the form, which includes instructions for submitting bills to OWCP. The provider must sign the form. For pharmacy expenses, you should use the Universal Claim Form, to include the name of the drug; name of prescribing physician and the date the prescription was filled.

Additionally, you must also complete Form CA-915, Claimant Medical Reimbursement Form, and submit a copy with each Form HCFA-1500, OWCP-1500, or Universal Claim Form. Claims for hospital charges must be submitted on Form UB-92. All forms are available through the ICPA office, or at:
http://www.dol.gov/dol/esa/public/regs/compliance/owcp/fecacont.htm
For payment reimbursement, it is recommended that you submit proof of payment, along with the proper forms. OWCP will accept signed statements by providers, a mechanical stamp showing receipt of payment, photocopies of canceled checks (both front and back), or a copy of a credit card receipt.

Both provider bills, and employee reimbursements must be submitted to OWCP within one year after the end of the calendar year in which the expense was incurred, the service was provided, or within a year after the end of the calendar year in which the treated condition was first accepted as compensable by OWCP.

You may review the status of bill submissions for your injury claim by entering the ACS website, and following instructions provided by that website. https://owcp.dol.acs-inc.com/portal/selectUserType.do?program-code=1&user-type=C

ENTITLEMENT TO COP

Continuation of Pay (COP) is an extension of your regular pay for up to 45 calendar days of wage loss due to disability and/or medical treatment. Your employer pays COP only for claims filed for traumatic injuries. When you request COP, your employer must continue your pay unless it controverts COP for one of the following reasons:

- the disability is due to an occupational disease or illness
- you serve without pay or nominal pay, or are appointed to the staff of a former President, or are selected pursuant to Chapter 121 of Title 28 and serve as a petit or grand juror, and are not otherwise an employee of the United States
- you are neither a citizen nor a resident of the United States or Canada (i.e., a foreign national employed outside the United States or Canada
- the injury occurred off the Agency premises and you were not engaged in authorized "off premises duties";

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

- the injury was caused by your willful misconduct; or by your intent to bring about injury or death of yourself or another person; or by your intoxication from alcohol or illegal drugs;
- the injury was not reported on a form approved by OWCP (usually Form CA-1) within 30 days after the injury
- you first stopped work more than 45 days after the injury
- you first reported the injury after employment ended
- You are enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, work-study program, or other group covered by special legislation

Your employer may stop COP if

- you do not provide appropriate medical evidence of a disabling traumatic injury within 10 calendar days of claiming COP. COP is reinstated where evidence received at a later date supports disability.
- your physician has found you to be partially disabled and you refuse suitable work, or fail to respond to the job offer.
- Your scheduled period of employment ends, or employment otherwise ends, provided the period of employment or date of termination is set before the injury occurs

COP can be stopped if employment ends due to disciplinary action in situations where preliminary written notice of termination or other action was issued before the injury occurred and the termination or other action became final during the COP period.

Also any continuation of pay (COP) granted to you after a claim is withdrawn must be charged to sick or annual leave, or considered an overpayment of pay consistent with 5 U.S.C. 5584, at your option.

LIGHT DUTY AVAILABILITY

Employees who are disabled from their regular jobs are expected to return to suitable light duty identified by the supervisor, or the ICPA office. If light duty work is available and offered, you must notify your attending physician and request him/her to specify the limitations and restrictions that apply. Thereafter, immediately advise your supervisor or the ICPA office of the limitations and restrictions imposed by your physician.

If offered light duty work within the limitations and restrictions imposed by your attending physician, you are obligated to return to duty unless you are entitled to, and request leave under FMLA. If you choose not to accept the light duty job offer, you may not be entitled to COP, or wage loss compensation from the OWCP.

CLAIMS FOR COMPENSATION

Compensation payments may be made after wage loss begins and the medical evidence shows that you cannot perform the duties of your regular job. For a traumatic injury, compensation is payable after the 45 days of COP have ended and three waiting days have elapsed. For traumatic injuries where there is no entitlement to COP, and for non-traumatic injuries, compensation is payable after three waiting days have elapsed. In either instance, no waiting period is required when permanent disability exists, or when the disability causing wage loss exceeds 14 days.

Compensation is paid at two-thirds of your pay rate if you have no dependents, or three-fourths of the pay rate if you are married or have one or more dependents. The pay rate is based on your pay on the date of injury, the date disability began, or the date of recurrence. The only regular deductions from compensation are for your share of health benefit premiums, optional life insurance, and post-retirement basic life withholdings if you are enrolled in these plans.

In order for you to claim compensation, you must be in a Leave-Without-Pay-Injury-On-Duty (LWOP-IOD) status with your employer.

Form CA-7, Claim for Compensation, is used to claim compensation for loss of pay. Each payment of compensation must be supported by a medical report from a physician that shows you are disabled for work during the period for which compensation is claimed. It is your responsibility to arrange for submittal of such medical reports.

LEAVE BUY-BACK

Instead of LWOP ("KD" hours type code), you may use sick or annual leave to cover disability periods, however, this is not required, or advised. Doing so can cost you a significant amount of money and delay to repurchase the leave used. It is often preferable to use LWOP (KD) and claim compensation instead.

The leave buy-back process allows you to repurchase annual and sick leave subject to your employer's

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

the decision of each individual agency. When your claim is approved and medical evidence show s that you w ere unable to w ork because of the injury during the period claimed; you may request a "leave buy-back." You must submit Forms CA-7, CA-7a and CA-7b to OWCP through the ICPA office.

You w ill ow e your employer the difference betw een the amount paid for leave, w hich is 100 percent of your usual w age rate, and the amount paid for compensation, w hich is tw o-thirds or three-fourths of the w age rate. When this difference is paid, your employer's payroll office w ill then restore the annual and sick leave to your account and replace them w ith LWOP (KD) hours. For each 80-hour increment of restored annual and sick leave that is converted to LWOP (KD), your leave account may be reduced by 4 hours of sick leave and either 4, 6 or 8 hours of annual leave dependent upon your leave accrual rate. The repurchase of leave can also affect your income taxes.

PERMANENT IMPAIRMENT

The FECA provides compensation for the permanent loss or loss of use of specified members, functions, and organs of the body. Payment is made for a specified number of days or w eeks according to the severity of the impairment. This kind of payment is called a schedule aw ard.

PENALTY FOR FALSE CLAIMS

Whoever know ingly and w illfully falsifies, conceals, or covers up a material fact, or makes a false, fictitious, or fraudulent statement or representation, or makes or uses a false statement or report know ing the same to contain any false, fictitious, or fraudulent statement or entry in connection w ith the application for or receipt of compensation or other benefit or payment under subchapter I or II of chapter 81 of title 5, shall be guilty of perjury, and on conviction thereof shall be punished by a fine under this title, or by imprisonment for not more than 5 years, or both; but if the amount of the benefits falsely obtained does not exceed $1,000, such person shall be punished by a fine under this title, or by imprisonment for not more than 1 year, or both. ~Federal law (18 U.S.C. 1920)

PRIVACY ACT INFORMATION

While w orkers' compensation records are protected from release under the Privacy Act, your employer is considered a party to the claim. The ICPA office may receive information in your file under the "routine use" provision of the regulations under w hich the Privacy Act is administered. Such information may include medical reports. The ICPA office is expected, how ever, to handle this information w ith care and to restrict access to those w ith a specific need to have it.

Figure 6. Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation," With Instructions, Continued

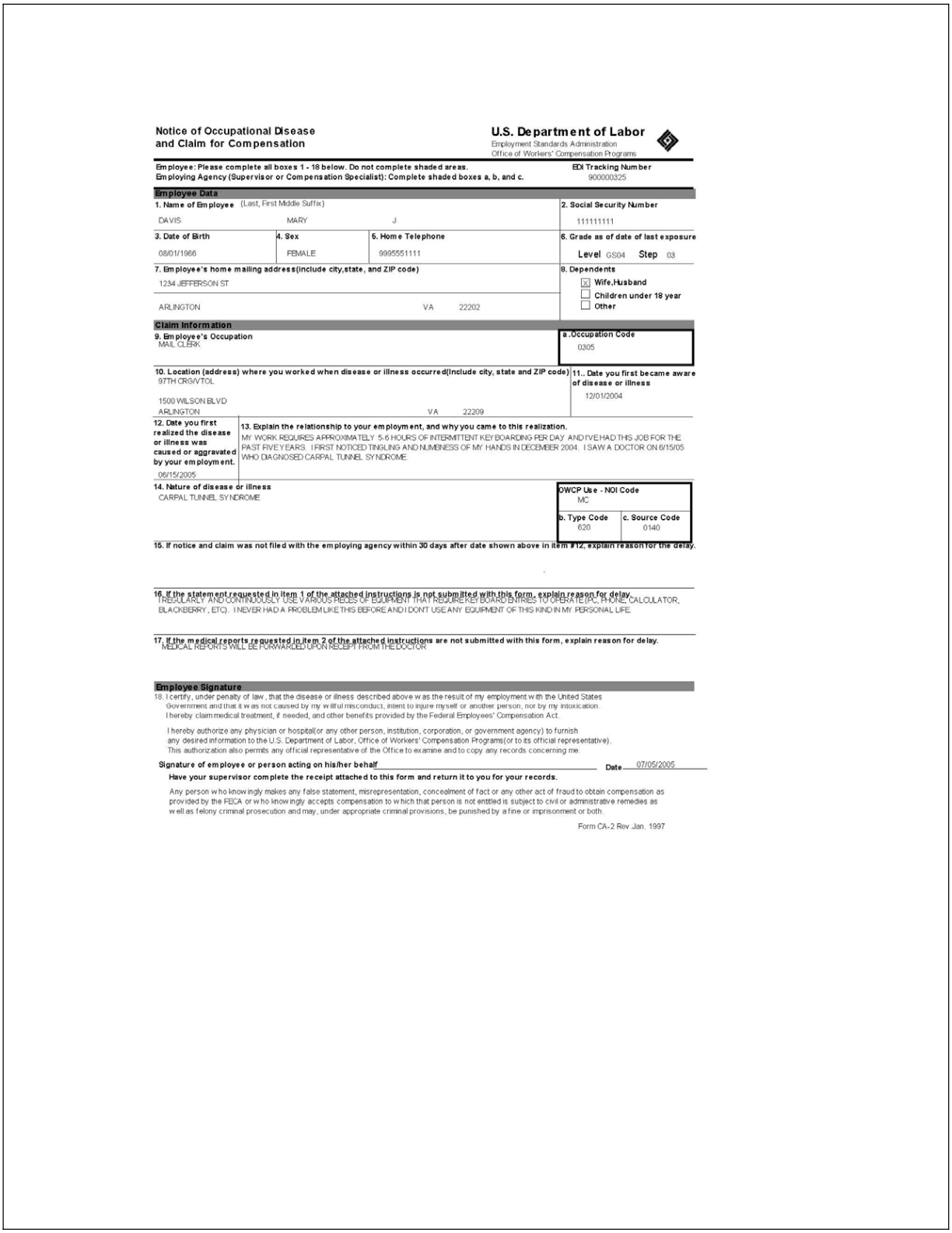
CPMS Instructions for Completing Form CA-1,
Federal Employee's Notice of Traumatic Injury
And claim for Continuation of Pay/Compensation

1. Refer to the Defense Portal and Analysis Center (DefPAC) Electronic Data Interchange (EDI) training module for detailed instruction for completing an electronic Form CA-1.

2. The ICPA retains a hard copy of the CA-1 that contains the signature of the employee, supervisor and any witness who may have observed the injury occur.

3. Provide the employee with the complete Electronic Data Interchange (EDI) Form CA-1. This includes: the claim, Instructions for Completing Form CA-1, Benefits for Employees Under the FECA, Privacy Act, Receipt of Notice of Injury, and Employee Rights and Responsibilities When Injured at Work.

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation"



Notice of Occupational Disease and Claim for Compensation

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

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

EDI Tracking Number
900000325

Employee Data

1. Name of Employee (Last, First Middle Suffix)
DAVIS MARY J

2. Social Security Number
111111111

3. Date of Birth
08/01/1966

4. Sex
FEMALE

6. Home Telephone
9995551111

6. Grade as of date of last exposure
Level GS04 Step 03

7. Employee's home mailing address(include city,state, and ZIP code)
1234 JEFFERSON ST
ARLINGTON VA 22202

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

Claim Information

9. Employee's Occupation
MAIL CLERK

a .Occupation Code
0305

10. Location (address) where you worked when disease or illness occurred(include city, state and ZIP code)
97TH CRG/VTOL
1500 WILSON BLVD
ARLINGTON VA 22209

11.. Date you first became aware of disease or illness
12/01/2004

12. Date you first realized the disease or illness was caused or aggravated by your employment.
06/15/2005

13. Explain the relationship to your employment, and why you came to this realization.
MY WORK REQUIRES APPROXIMATELY 5-6 HOURS OF INTERMITTENT KEYBOARDING PER DAY. AND I'VE HAD THIS JOB FOR THE PAST FIVE YEARS. I FIRST NOTICED TINGLING AND NUMENESS OF MY HANDS IN DECEMBER 2004. I SAW A DOCTOR ON 6/15/05 WHO DIAGNOSED CARPAL TUNNEL SYNDROME.

14. Nature of disease or illness
CARPAL TUNNEL SYNDROME

OWCP Use - NOI Code
MC

b. Type Code
620

c. Source Code
0140

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

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
I REGULARLY AND CONTINUOUSLY USE VARIOUS PIECES OF EQUIPMENT THAT REQUIRE KEYBOARD ENTRIES TO OPERATE (PC, PHONE, CALCULATOR, BLACKBERRY, ETC). I NEVER HAD A PROBLEM LIKE THIS BEFORE AND I DONT USE ANY EQUIPMENT OF THIS KIND IN MY PERSONAL LIFE.

17. If the medical reports requested in item 2 of the attached instructions are not submitted with this form, explain reason for delay.
MEDICAL REPORTS WILL BE FORWARDED UPON RECEIPT FROM THE DOCTOR

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.

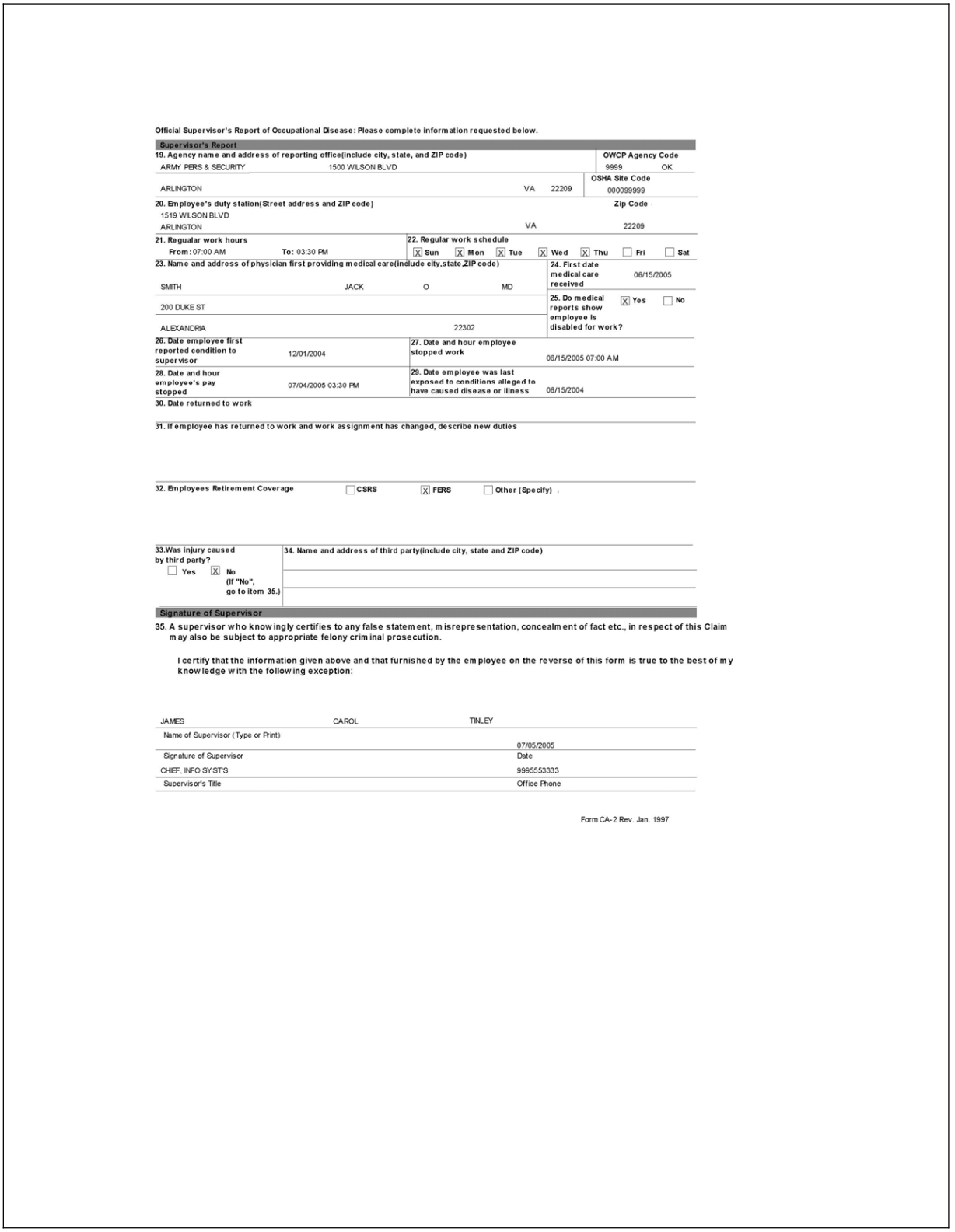
Signature of employee or person acting on his/her behalf _____ **Date** 07/05/2005

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.

Form CA-2 Rev. Jan. 1997

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued



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)
ARMY PERS & SECURITY 1500 WILSON BLVD
ARLINGTON VA 22209
OWCP Agency Code 9999 OK
OSHA Site Code 000099999

20. Employee's duty station(Street address and ZIP code)
1519 WILSON BLVD
ARLINGTON VA 22209
Zip Code

21. Regualar work hours
From: 07:00 AM **To:** 03:30 PM

22. Regular work schedule
[X] Sun [X] Mon [X] Tue [X] Wed [X] Thu [ ] Fri [ ] Sat

23. Name and address of physician first providing medical care(include city,state,ZIP code)
SMITH JACK O MD
200 DUKE ST
ALEXANDRIA 22302

24. First date medical care received 06/15/2005

25. Do medical reports show employee is disabled for work? [X] Yes [ ] No

26. Date employee first reported condition to supervisor 12/01/2004

27. Date and hour employee stopped work 06/15/2005 07:00 AM

28. Date and hour employee's pay stopped 07/04/2005 03:30 PM

29. Date employee was last exposed to conditions alleged to have caused disease or illness 06/15/2004

30. Date returned to work

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

32. Employees Retirement Coverage [ ] CSRS [X] FERS [ ] Other (Specify)

33.Was injury caused by third party? [ ] Yes [X] No (If "No", go to item 35.)

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 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:

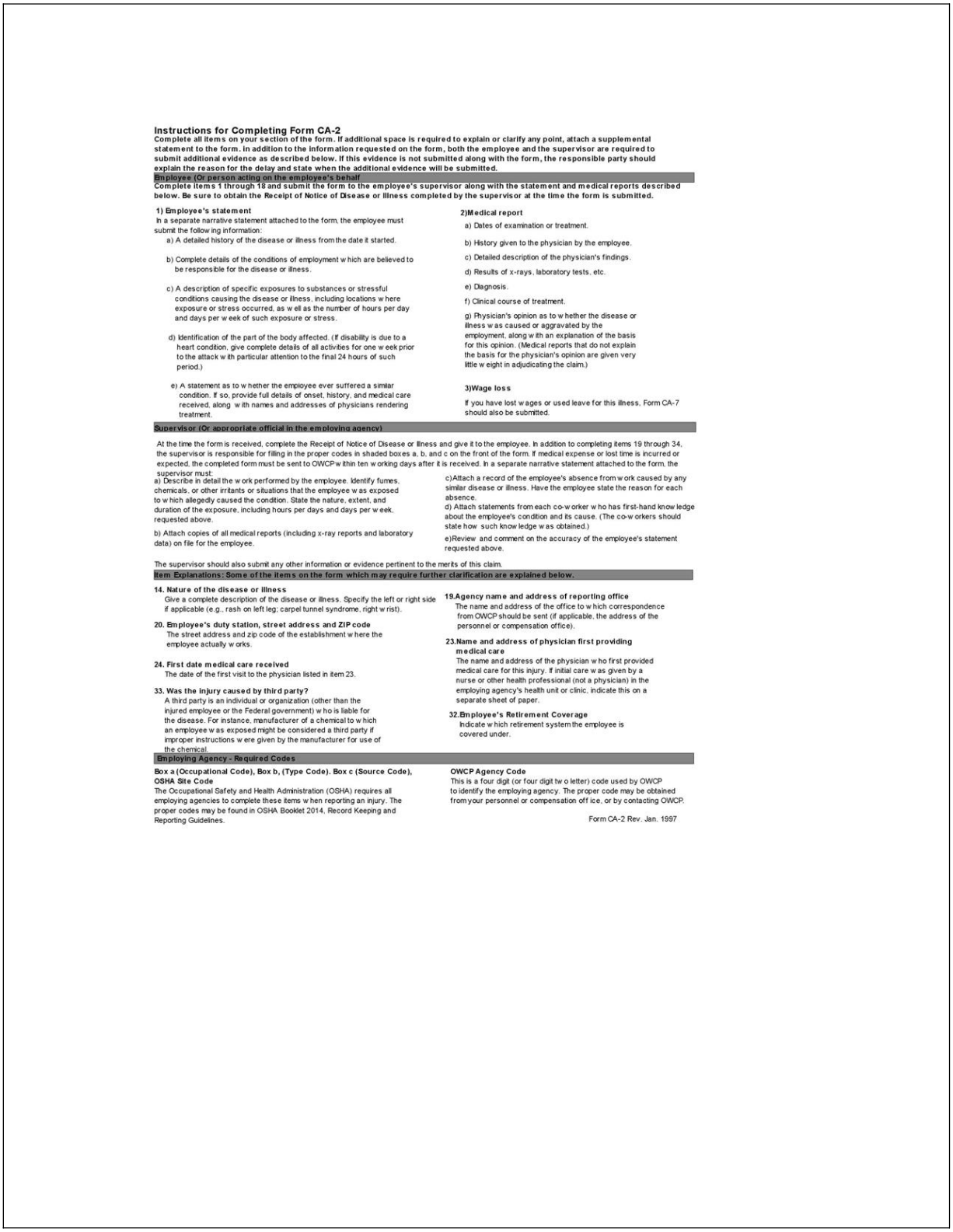
JAMES CAROL TINLEY
Name of Supervisor (Type or Print)

07/05/2005
Signature of Supervisor — Date

CHIEF, INFO SYST'S
Supervisor's Title — Office Phone 9995553333

Form CA-2 Rev. Jan. 1997

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued



Instructions for Completing Form CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (Or person acting on the employee's behalf

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

1) Employee's statement

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

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

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

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

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

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

2)Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Detailed description of the physician's findings.

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

e) Diagnosis.

f) Clinical course of treatment.

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

3)Wage loss

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

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

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

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

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

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

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

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

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

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

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

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

33. Was the injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

19.Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

23.Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

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

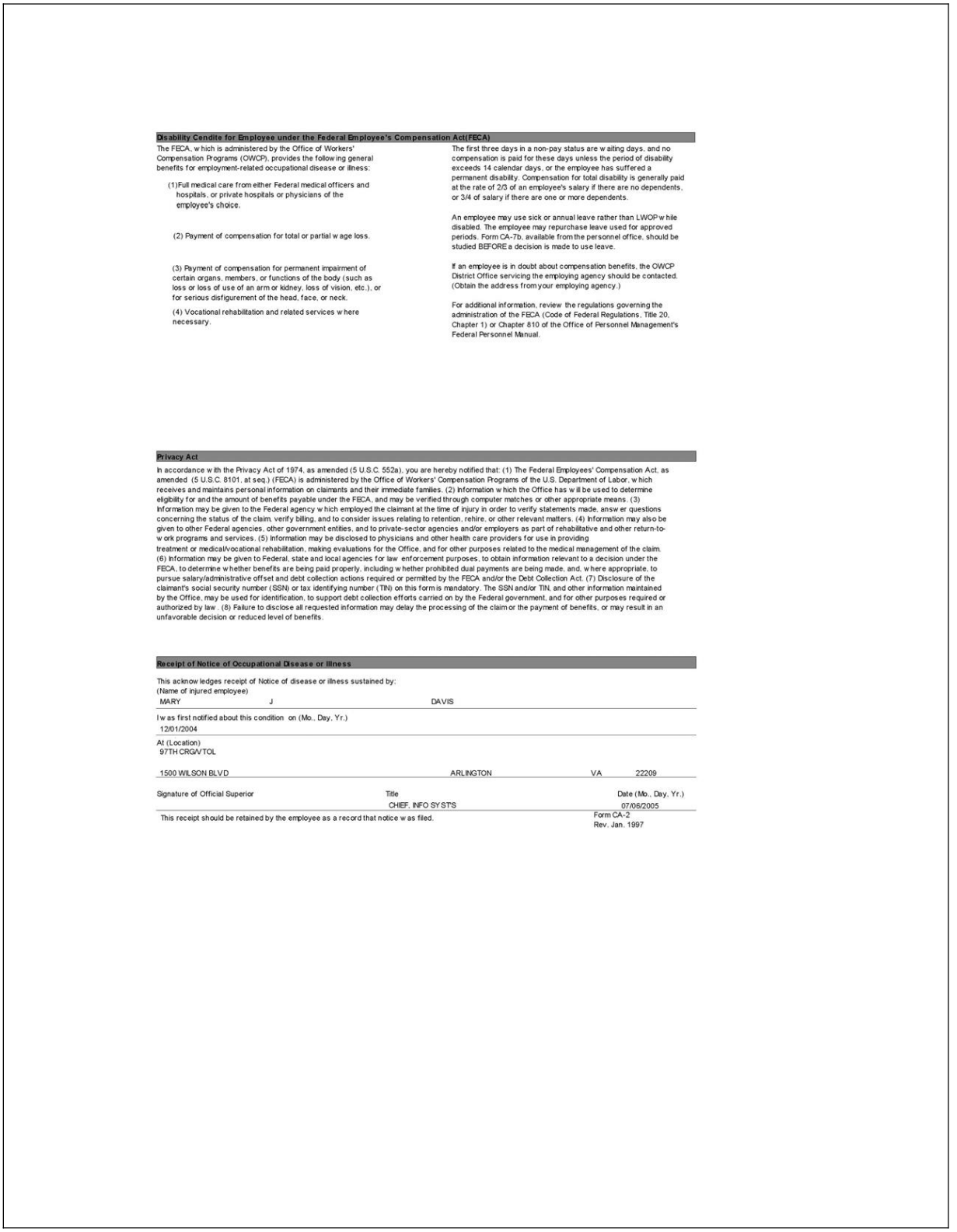
Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code). Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-2 Rev. Jan. 1997

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued



Disability Cendite for Employee under the Federal Employee's Compensation Act(FECA)

The FECA, w hich is administered by the Office of Workers' Compensation Programs (OWCP), provides the follow ing 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 w age 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 w here necessary.

The first three days in a non-pay status are w aiting 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 w hile disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

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

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

Privacy Act

In accordance w ith the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, at seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, w hich receives and maintains personal information on claimants and their immediate families. (2) Information w hich the Office has w ill 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 w hich employed the claimant at the time of injury in order to verify statements made, answ er 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-w ork 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 w hether benefits are being paid properly, including w hether prohibited dual payments are being made, and, w here 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.

Receipt of Notice of Occupational Disease or Illness

This acknow ledges receipt of Notice of disease or illness sustained by:
(Name of injured employee)

MARY	J	DAVIS

I w as first notified about this condition on (Mo., Day, Yr.)
12/01/2004

At (Location)
97TH CRG/VTOL

1500 WILSON BLVD	ARLINGTON	VA	22209

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
	CHIEF, INFO SYSTS	07/06/2005

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

Form CA-2
Rev. Jan. 1997

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued

EMPLOYEE RIGHTS AND RESPONSIBILITIES WHEN INJURED AT WORK

It has come to our attention that you have been involved in a work-related accident. We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA) should you file a workers' compensation claim.

The Office of Workers' Compensation Programs (OWCP) administers the FECA and has sole adjudication authority for federal workers' compensation claims. The ICPA office, in conjunction with the Civilian Personnel Management Service, Injury & Unemployment Compensation Division, is responsible for monitoring your entitlement to the benefits outlined within the FECA and administered by the OWCP.

FILING A WORKERS' COMPENSATION CLAIM

If you voluntarily elect to file a workers' compensation claim in relation to the reported accident, please complete the on-line OWCP Form CA-1 or CA-2 with your supervisor.

Form CA-1, Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation may be completed to report a traumatic injury, which is an injury that has occurred within one tour of your regular duty. Form CA-1 should be filed within 30 days of the injury.

Form CA-2, Notice of Occupational Disease and Claim for Compensation, may be completed to report an occupational disease, which is an injury or illness that has developed over a period greater than one tour of official duty. Form CA-2 should be filed within 30 days of the date you realized the disease or illness was caused or aggravated by the employment.

When filing a claim for Occupational Disease or Illness, you must submit the specific detailed information described on Form CA-2 and on any checklist (Form CA-35, A-H) provided by your supervisor or the human resources office. OWCP has developed these checklists to address particular occupational diseases. Medical reports must also include the information specified on the checklist for the particular disease claimed.

Once a claim has been filed with the OWCP, you have the right to withdraw your workers' compensation claim, (but not the notice of injury) by so requesting in writing to OWCP through your responsible ICPA office at any time before OWCP determines eligibility for benefits.

OBTAINING MEDICAL TREATMENT

You have a right to choose your treating physician. You must notify your supervisor of your preferred choice prior to scheduling an appointment. Any request by your supervisor or the occupational health clinic to be evaluated by medical clinic or contract physician must not interfere with your preferred physician appointment.

When an appointment with your preferred physician is requested for a traumatic injury, your supervisor may complete the front of Form CA-16, "Authorization for Examination and/or Treatment". In an emergency, where there is no time to complete the form, the ICPA office may authorize medical treatment by telephone and then forward Form CA-16 to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is not allowed under any other circumstance. Your supervisor, or the ICPA office may refuse to issue a CA-16 if more than 48 hours has elapsed since the injury occurred, or the treatment is based on an Occupational Disease or Illness.

If you require medical treatment because of a work-related occupational illness, it is recommended that you obtain care directly from a physician, preferably from a specialist in the indicated field. If OWCP accepts the claim, medical treatment required by the condition(s) accepted, including treatment received before acceptance may be reimbursed to you or your health insurance carrier by the OWCP after adjudication. Form CA-16 may not be used to authorize treatment for occupational disease or illness except in very unusual situations.

For each type of claim, you are responsible for submitting, or arranging for submittal of a medical report from the treating physician for every medical service provided to you resulting from the job-related injury. You must also submit medical evidence showing that the condition claimed is disabling when applying for wage loss benefits.

Medical reports from service providers must include the following:

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued

- Dates of examination and treatment
- History given by you
- Physical findings
- Results of diagnostic tests
- Diagnosis
- A description of any other conditions found but not due to the claimed injury;
- Treatment provided or recommended for the claimed injury
- Physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;
- Extent of disability affecting your ability to work due to the injury;
- Prognosis for recovery; and
- Work limitations

MEDICAL BILL PAYMENTS

Your provider has the option of sending bills for injury-related treatment or services electronically, or in paper form. Providers that elect to submit bills electronically must enroll as a DOL provider by completing the Provider Enrollment Form at the following web address:
https://owcp.dol.acs-inc.com/portal/pdf/Provider_Enrollment_Form_Final.pdf

OWCP will pay appropriate charges for medical treatment if your case is approved and the treatment was necessary for the job-related injury. OWCP applies a schedule of maximum allowable medical charges to pay work-related bills submitted by a provider of service. OWCP will only authorize payment of treatment or services that are related to an accepted work-related condition.

You are not responsible for paying the difference between the maximum charge set by the schedule for a particular treatment and the charge made by the provider for bills submitted on an OWCP accepted claim. You are, however, responsible for payment of medical bills resulting from an occupational disease or illness until a claim is accepted by the OWCP.

You may be reimbursed for employee-paid medical, surgical, and dental services using Form **HCFA-1500, American Medical Association Standard Health Insurance Claim Form**, or **OWCP-1500**, the version of the form, which includes instructions for submitting bills to OWCP. The provider must sign the form. For pharmacy expenses, you should use the Universal Claim Form, to include the name of the drug; name of prescribing physician and the date the prescription was filled.

Additionally, you must also complete Form CA-915, Claimant Medical Reimbursement Form, and submit a copy with each Form HCFA-1500, OWCP-1500, or Universal Claim Form. Claims for hospital charges must be submitted on Form UB-92. All forms are available through the ICPA office, or at:
http://www.dol.gov/dol/esa/public/regs/compliance/owcp/fecacont.htm
For payment reimbursement, it is recommended that you submit proof of payment, along with the proper forms. OWCP will accept signed statements by providers, a mechanical stamp showing receipt of payment, photocopies of canceled checks (both front and back), or a copy of a credit card receipt.

Both provider bills, and employee reimbursements must be submitted to OWCP within one year after the end of the calendar year in which the expense was incurred, the service was provided, or within a year after the end of the calendar year in which the treated condition was first accepted as compensable by OWCP.

You may review the status of bill submissions for your injury claim by entering the ACS website, and following instructions provided by that website. https://owcp.dol.acs-inc.com/portal/selectUserType.do?program-code=1&user-type=C

ENTITLEMENT TO COP

Continuation of Pay (COP) is an extension of your regular pay for up to 45 calendar days of wage loss due to disability and/or medical treatment. Your employer pays COP only for claims filed for traumatic injuries. When you request COP, your employer must continue your pay unless it controverts COP for one of the following reasons:

- the disability is due to an occupational disease or illness
- you serve without pay or nominal pay, or are appointed to the staff of a former President, or are selected pursuant to Chapter 121 of Title 28 and serve as a petit or grand juror, and are not otherwise an employee of the United States
- you are neither a citizen nor a resident of the United States or Canada (i.e., a foreign national employed outside the United States or Canada
- the injury occurred off the Agency premises and you were not engaged in authorized "off premises duties";

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued

- the injury was caused by your willful misconduct; or by your intent to bring about injury or death of yourself or another person; or by your intoxication from alcohol or illegal drugs;
- the injury was not reported on a form approved by OWCP (usually Form CA-1) within 30 days after the injury
- you first stopped work more than 45 days after the injury
- you first reported the injury after employment ended
- You are enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, work-study program, or other group covered by special legislation

Your employer may stop COP if

- you do not provide appropriate medical evidence of a disabling traumatic injury within 10 calendar days of claiming COP. COP is reinstated where evidence received at a later date supports disability.
- your physician has found you to be partially disabled and you refuse suitable work, or fail to respond to the job offer.
- Your scheduled period of employment ends, or employment otherwise ends, provided the period of employment or date of termination is set before the injury occurs

COP can be stopped if employment ends due to disciplinary action in situations where preliminary written notice of termination or other action was issued before the injury occurred and the termination or other action became final during the COP period.

Also any continuation of pay (COP) granted to you after a claim is withdrawn must be charged to sick or annual leave, or considered an overpayment of pay consistent with 5 U.S.C. 5584, at your option.

LIGHT DUTY AVAILABILITY

Employees who are disabled from their regular jobs are expected to return to suitable light duty identified by the supervisor, or the ICPA office. If light duty work is available and offered, you must notify your attending physician and request him/her to specify the limitations and restrictions that apply. Thereafter, immediately advise your supervisor or the ICPA office of the limitations and restrictions imposed by your physician.

If offered light duty work within the limitations and restrictions imposed by your attending physician, you are obligated to return to duty unless you are entitled to, and request leave under FMLA. If you choose not to accept the light duty job offer, you may not be entitled to COP, or wage loss compensation from the OWCP.

CLAIMS FOR COMPENSATION

Compensation payments may be made after wage loss begins and the medical evidence shows that you cannot perform the duties of your regular job. For a traumatic injury, compensation is payable after the 45 days of COP have ended and three waiting days have elapsed. For traumatic injuries where there is no entitlement to COP, and for non-traumatic injuries, compensation is payable after three waiting days have elapsed. In either instance, no waiting period is required when permanent disability exists, or when the disability causing wage loss exceeds 14 days.

Compensation is paid at two-thirds of your pay rate if you have no dependents, or three-fourths of the pay rate if you are married or have one or more dependents. The pay rate is based on your pay on the date of injury, the date disability began, or the date of recurrence. The only regular deductions from compensation are for your share of health benefit premiums, optional life insurance, and post-retirement basic life withholdings if you are enrolled in these plans.

In order for you to claim compensation, you must be in a Leave-Without-Pay-Injury-On-Duty (LWOP-IOD) status with your employer.

Form CA-7, Claim for Compensation, is used to claim compensation for loss of pay. Each payment of compensation must be supported by a medical report from a physician that shows you are disabled for work during the period for which compensation is claimed. It is your responsibility to arrange for submittal of such medical reports.

LEAVE BUY-BACK

Instead of LWOP ("KD" hours type code), you may use sick or annual leave to cover disability periods, however, this is not required, or advised. Doing so can cost you a significant amount of money and delay to repurchase the leave used. It is often preferable to use LWOP (KD) and claim compensation instead.

The leave buy-back process allows you to repurchase annual and sick leave subject to your employer's guidelines. OWCP does not require that your employer grant your leave buy-back request. This is solely

Figure 7. Form CA-2, "Notice of Occupational Disease and Claim for Compensation," Continued

the decision of each individual agency. When your claim is approved and medical evidence shows that you were unable to work because of the injury during the period claimed; you may request a "leave buy-back." You must submit Forms CA-7, CA-7a and CA-7b to OWCP through the ICPA office.

You will owe your employer the difference between the amount paid for leave, which is 100 percent of your usual wage rate, and the amount paid for compensation, which is two-thirds or three-fourths of the wage rate. When this difference is paid, your employer's payroll office will then restore the annual and sick leave to your account and replace them with LWOP (KD) hours. For each 80-hour increment of restored annual and sick leave that is converted to LWOP (KD), your leave account may be reduced by 4 hours of sick leave and either 4, 6 or 8 hours of annual leave dependent upon your leave accrual rate. The repurchase of leave can also affect your income taxes.

PERMANENT IMPAIRMENT

The FECA provides compensation for the permanent loss or loss of use of specified members, functions, and organs of the body. Payment is made for a specified number of days or weeks according to the severity of the impairment. This kind of payment is called a schedule award.

PENALTY FOR FALSE CLAIMS

Whoever knowingly and willfully falsifies, conceals, or covers up a material fact, or makes a false, fictitious, or fraudulent statement or representation, or makes or uses a false statement or report knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the application for or receipt of compensation or other benefit or payment under subchapter I or III of chapter 81 of title 5, shall be guilty of perjury, and on conviction thereof shall be punished by a fine under this title, or by imprisonment for not more than 5 years, or both; but if the amount of the benefits falsely obtained does not exceed $1,000, such person shall be punished by a fine under this title, or by imprisonment for not more than 1 year, or both. ~Federal law (18 U.S.C. 1920)

PRIVACY ACT INFORMATION

While workers' compensation records are protected from release under the Privacy Act, your employer is considered a party to the claim. The ICPA office may receive information in your file under the "routine use" provision of the regulations under which the Privacy Act is administered. Such information may include medical reports. The ICPA office is expected, however, to handle this information with care and to restrict access to those with a specific need to have it.

Figure 8. Instructions for Completing Form CA-2

CPMS Instructions for Completing Form CA-2,
Notice of Occupational Disease and Claim for Compensation

1. Refer to the Defense Portal and Analysis Center (DefPAC) Electronic Data Interchange (EDI) training module for detailed instruction for completing an electronic Form CA-2.

2. The ICPA retains a hard copy of the CA-2 that contains the original signature of the employee and supervisor.

3. Provide the employee with the complete Electronic Data Interchange (EDI) Form CA-2. This includes: the claim, Instructions for Completing Form CA-2, Disability Benefits for Employees Under the FECA, Privacy Act, Receipt of Notice of Injury, and Employee Rights and Responsibilities When Injured at Work.

Figure 9. Form CA-2a, "Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation"

Notice of Recurrence

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

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

OMB No. 1215-0187
Expires: 08-31-99

Part A - Employee

1. Name of employee (Last, First, Middle)
JONES, John E.

2. Social Security Number
111-22-3344

3. OWCP file number for original injury
A00-123456

4. Date of birth Mo. Day Yr.
06 02 57

5. Sex
[X] Male [ ] Female

6. Home telephone
(111) 234-5678

7. Home mailing address (include city, state, and ZIP code)
318 Pine Street
Richmond, VA 23297

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)
Naval Weapons Station
Code 0641
Yorktown, VA 23297

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

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)
11/5/94 1:30 PM	2/3/95 10:15 AM	2/3/95 10:15 AM	Hasnt stopped	N/A

16. This Claim is for:
[ ] Medical Treatment Only
[X] Time Loss From Work

17. Date of first medical treatment following recurrence (mo., day, year)
2/3/95

18. Name and address of treating physician
A.C. Jones, MD
1098 Smith Rd.
Richmond, VA 23297

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? [X] Yes [ ] No (If so, explain. Also state how long these limitations continued.)
limited to lifting no more than 20 pounds. usual duties require 40 pound lifting

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
continued to have moderate back pain--participated in therapy program and did back strengthening exercises at home.

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
doing paperwork at desk when back pain became severe, I was doing nothing different from day to day duties.

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.
I have had no injuries or illnesses since the original injury.

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.

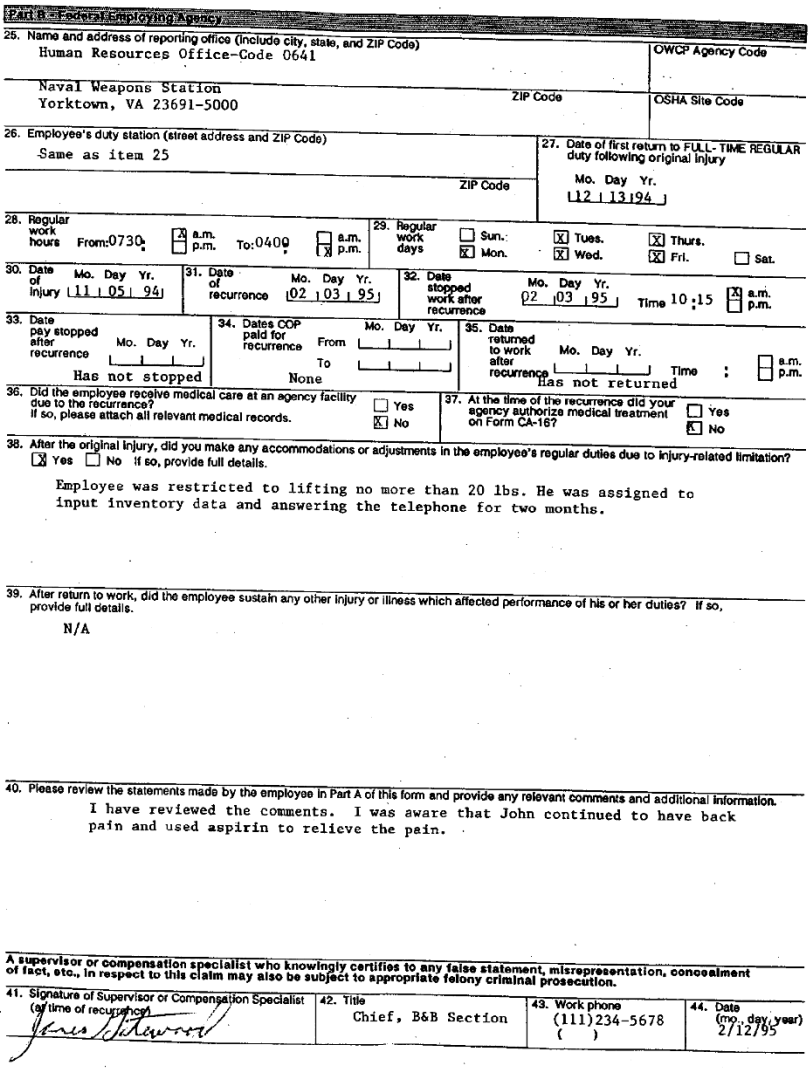
I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee
[signature]

24. Date (mo., day, year)
2/7/95

Form CA-2a

Figure 9. Form CA-2a, "Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation," Continued



Part B - Federal Employing Agency

25. Name and address of reporting office (include city, state, and ZIP Code)
Human Resources Office-Code 0641

Naval Weapons Station
Yorktown, VA 23691-5000

ZIP Code

OWCP Agency Code

OSHA Site Code

26. Employee's duty station (street address and ZIP Code)
Same as item 25

ZIP Code

27. Date of first return to FULL-TIME REGULAR duty following original injury
Mo. Day Yr.
12 13 94

28. Regular work hours From: 0730 [X] a.m. [ ] p.m. To: 0400 [ ] a.m. [X] p.m.

29. Regular work days [ ] Sun. [X] Mon. [X] Tues. [X] Wed. [X] Thurs. [X] Fri. [ ] Sat.

30. Date of injury Mo. Day Yr. 11 05 94

31. Date of recurrence Mo. Day Yr. 02 03 95

32. Date stopped work after recurrence Mo. Day Yr. 02 03 95 Time 10:15 [X] a.m. [ ] p.m.

33. Date pay stopped after recurrence Mo. Day Yr.
Has not stopped

34. Dates COP paid for recurrence From Mo. Day Yr.
To
None

35. Date returned to work after recurrence Mo. Day Yr. Time : [ ] a.m. [ ] p.m.
Has not returned

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

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

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

Employee was restricted to lifting no more than 20 lbs. He was assigned to input inventory data and answering the telephone for two months.

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.

N/A

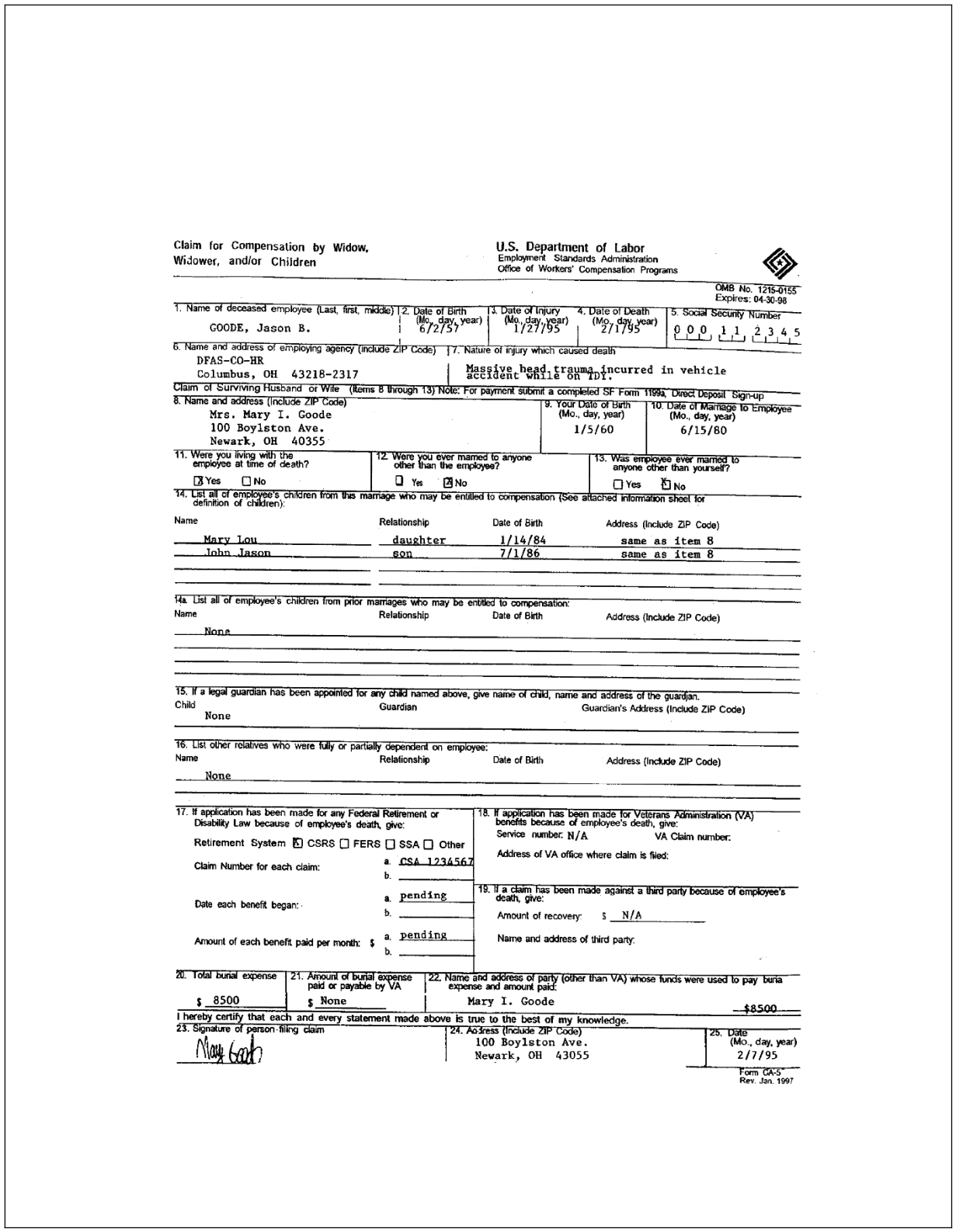
40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

I have reviewed the comments. I was aware that John continued to have back pain and used aspirin to relieve the pain.

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)
James Stewart	Chief, B&B Section	(111)234-5678 ( )	2/12/95

Figure 10. Form CA-5, "Claim for Compensation by Widow, Widower, and/or Children"



Claim for Compensation by Widow, Widower, and/or Children

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

OMB No. 1215-0155
Expires: 04-30-98

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number
GOODE, Jason B.	6/2/57	1/27/95	2/1/95	000 11 2345

6. Name and address of employing agency (include ZIP Code)
DFAS-CO-HR
Columbus, OH 43218-2317

7. Nature of injury which caused death
Massive head trauma, incurred in vehicle accident while on TDY.

Claim of Surviving Husband or Wife (Items 8 through 13) Note: For payment submit a completed SF Form 1199a, Direct Deposit Sign-up

8. Name and address (include ZIP Code)
Mrs. Mary I. Goode
100 Boylston Ave.
Newark, OH 40355

9. Your Date of Birth (Mo., day, year): 1/5/60

10. Date of Marriage to Employee (Mo., day, year): 6/15/80

11. Were you living with the employee at time of death? ☒ Yes ☐ No

12. Were you ever married to anyone other than the employee? ☐ Yes ☒ No

13. Was employee ever married to anyone other than yourself? ☐ Yes ☒ No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children):

Name	Relationship	Date of Birth	Address (Include ZIP Code)
Mary Lou	daughter	1/14/84	same as item 8
John Jason	son	7/1/86	same as item 8

14a. List all of employee's children from prior marriages who may be entitled to compensation:

Name	Relationship	Date of Birth	Address (Include ZIP Code)
None			

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include ZIP Code)
None		

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include ZIP Code)
None			

17. If application has been made for any Federal Retirement or Disability Law because of employee's death, give:
Retirement System ☒ CSRS ☐ FERS ☐ SSA ☐ Other
Claim Number for each claim: a. CSA 1234567 b.
Date each benefit began: a. pending b.
Amount of each benefit paid per month: $ a. pending b.

18. If application has been made for Veterans Administration (VA) benefits because of employee's death, give:
Service number: N/A VA Claim number:
Address of VA office where claim is filed:

19. If a claim has been made against a third party because of employee's death, give:
Amount of recovery: $ N/A
Name and address of third party:

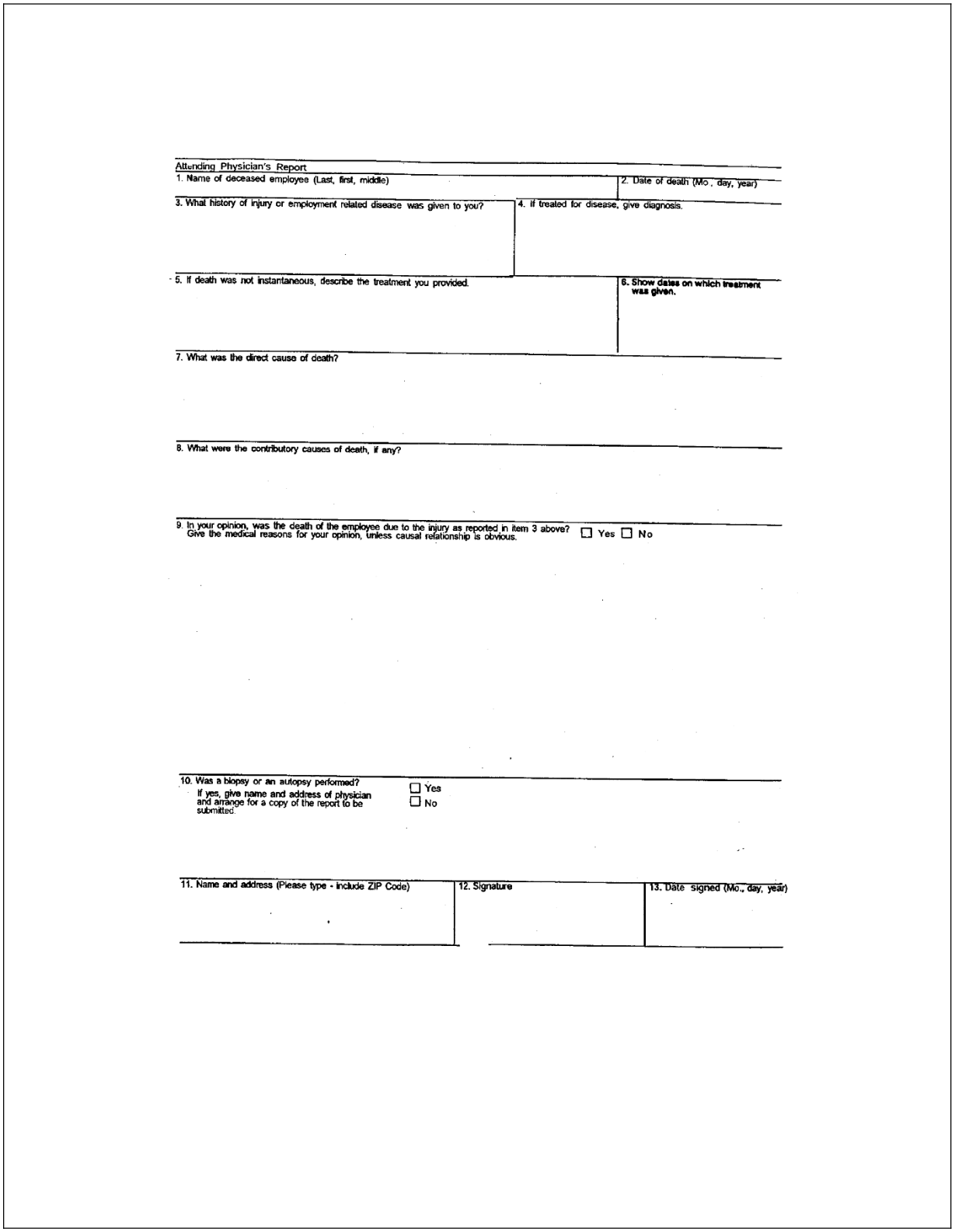
20. Total burial expense	21. Amount of burial expense paid or payable by VA	22. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$ 8500	$ None	Mary I. Goode $8500

I hereby certify that each and every statement made above is true to the best of my knowledge.

23. Signature of person filing claim	24. Address (Include ZIP Code)	25. Date (Mo., day, year)
Mary Goode	100 Boylston Ave. Newark, OH 43055	2/7/95

Form CA-5
Rev. Jan. 1997

Figure 10. Form CA-5, "Claim for Compensation by Widow, Widower, and/or Children," Continued



Attending Physician's Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (Mo., day, year)

3. What history of injury or employment related disease was given to you?

4. If treated for disease, give diagnosis.

5. If death was not instantaneous, describe the treatment you provided.

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? ☐ Yes ☐ No
Give the medical reasons for your opinion, unless causal relationship is obvious.

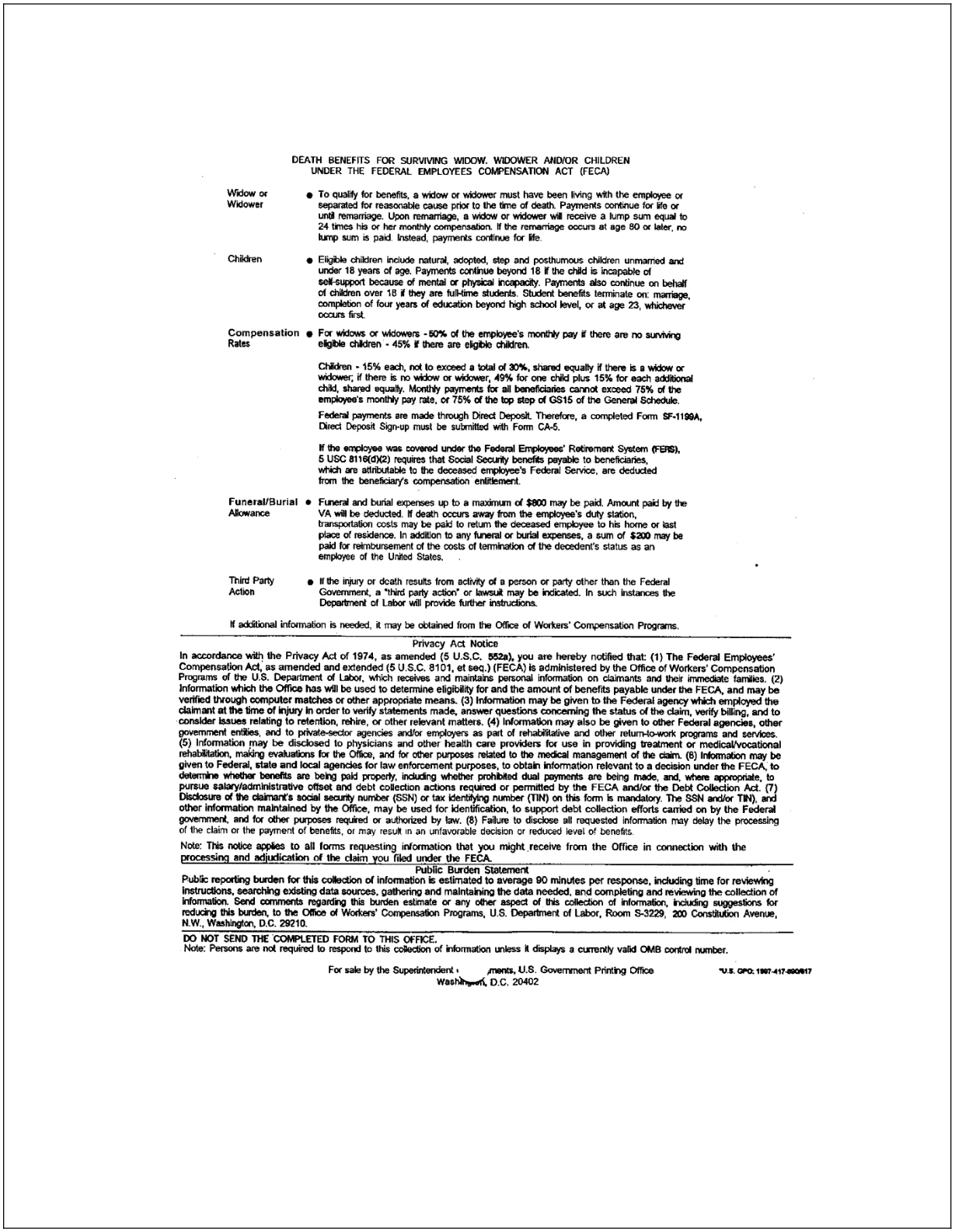
10. Was a biopsy or an autopsy performed? ☐ Yes ☐ No
If yes, give name and address of physician and arrange for a copy of the report to be submitted.

11. Name and address (Please type - include ZIP Code)

12. Signature

13. Date signed (Mo., day, year)

Figure 10. Form CA-5, "Claim for Compensation by Widow, Widower, and/or Children," Continued



DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN UNDER THE FEDERAL EMPLOYEES COMPENSATION ACT (FECA)

Widow or Widower

- To qualify for benefits, a widow or widower must have been living with the employee or separated for reasonable cause prior to the time of death. Payments continue for life or until remarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 80 or later, no lump sum is paid. Instead, payments continue for life.

Children

- Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate on: marriage, completion of four years of education beyond high school level, or at age 23, whichever occurs first.

Compensation Rates

- For widows or widowers - 50% of the employee's monthly pay if there are no surviving eligible children - 45% if there are eligible children.

  Children - 15% each, not to exceed a total of 30%, shared equally if there is a widow or widower; if there is no widow or widower, 49% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS15 of the General Schedule.

  Federal payments are made through Direct Deposit. Therefore, a completed Form SF-1199A, Direct Deposit Sign-up must be submitted with Form CA-5.

  If the employee was covered under the Federal Employees' Retirement System (FERS), 5 USC 8116(d)(2) requires that Social Security benefits payable to beneficiaries, which are attributable to the deceased employee's Federal Service, are deducted from the beneficiary's compensation entitlement.

Funeral/Burial Allowance

- Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.

Third Party Action

- If the injury or death results from activity of a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Privacy Act Notice

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.

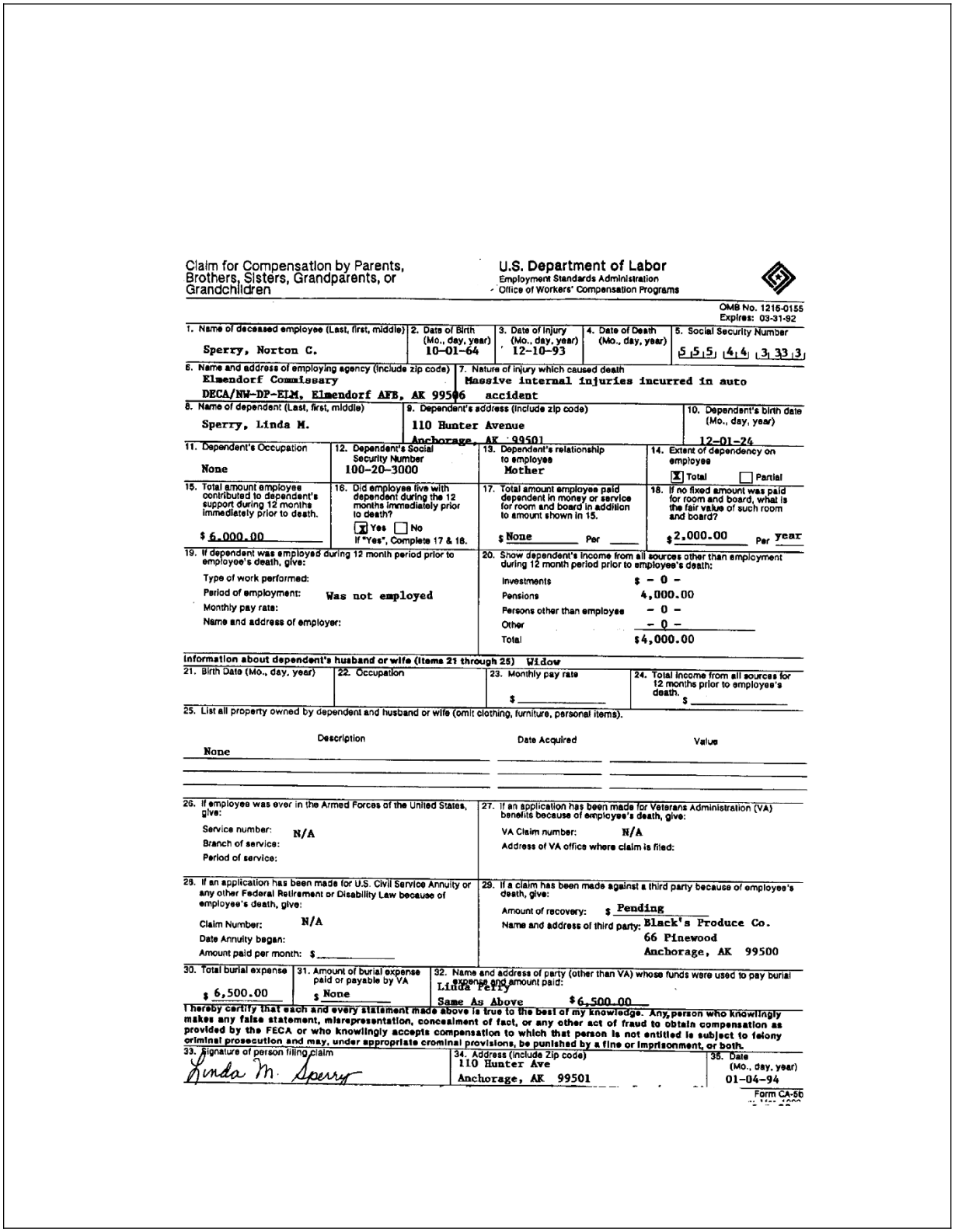
Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 29210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402
*U.S. GPO: 1997-417-690/617

Figure 11. Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren"



Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

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

OMB No. 1215-0155
Expires: 03-31-92

1. Name of deceased employee (Last, first, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security Number
Sperry, Norton C.	10-01-64	12-10-93		555 44 3333

6. Name and address of employing agency (include zip code)	7. Nature of injury which caused death
Elmendorf Commissary DECA/NW-DP-ELM, Elmendorf AFB, AK 99506	Massive internal injuries incurred in auto accident

8. Name of dependent (Last, first, middle)	9. Dependent's address (include zip code)	10. Dependent's birth date (Mo., day, year)
Sperry, Linda M.	110 Hunter Avenue Anchorage, AK 99501	12-01-24

11. Dependent's Occupation	12. Dependent's Social Security Number	13. Dependent's relationship to employee	14. Extent of dependency on employee
None	100-20-3000	Mother	[X] Total [ ] Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.	16. Did employee live with dependent during the 12 months immediately prior to death?	17. Total amount employee paid dependent in money or service for room and board in addition to amount shown in 15.	18. If no fixed amount was paid for room and board, what is the fair value of such room and board?
$ 6,000.00	[X] Yes [ ] No If "Yes", Complete 17 & 18.	$ None Per ____	$ 2,000.00 Per year

19. If dependent was employed during 12 month period prior to employee's death, give:	20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:	
Type of work performed:	Investments	$ - 0 -
Period of employment: Was not employed	Pensions	4,000.00
Monthly pay rate:	Persons other than employee	- 0 -
Name and address of employer:	Other	- 0 -
	Total	$4,000.00

Information about dependent's husband or wife (items 21 through 25) Widow

21. Birth Date (Mo., day, year)	22. Occupation	23. Monthly pay rate	24. Total income from all sources for 12 months prior to employee's death.
		$	$

25. List all property owned by dependent and husband or wife (omit clothing, furniture, personal items).

Description	Date Acquired	Value
None		

26. If employee was ever in the Armed Forces of the United States, give:	27. If an application has been made for Veterans Administration (VA) benefits because of employee's death, give:
Service number: N/A	VA Claim number: N/A
Branch of service:	Address of VA office where claim is filed:
Period of service:	

28. If an application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:	29. If a claim has been made against a third party because of employee's death, give:
Claim Number: N/A	Amount of recovery: $ Pending
Date Annuity began:	Name and address of third party: Black's Produce Co. 66 Pinewood Anchorage, AK 99500
Amount paid per month: $	

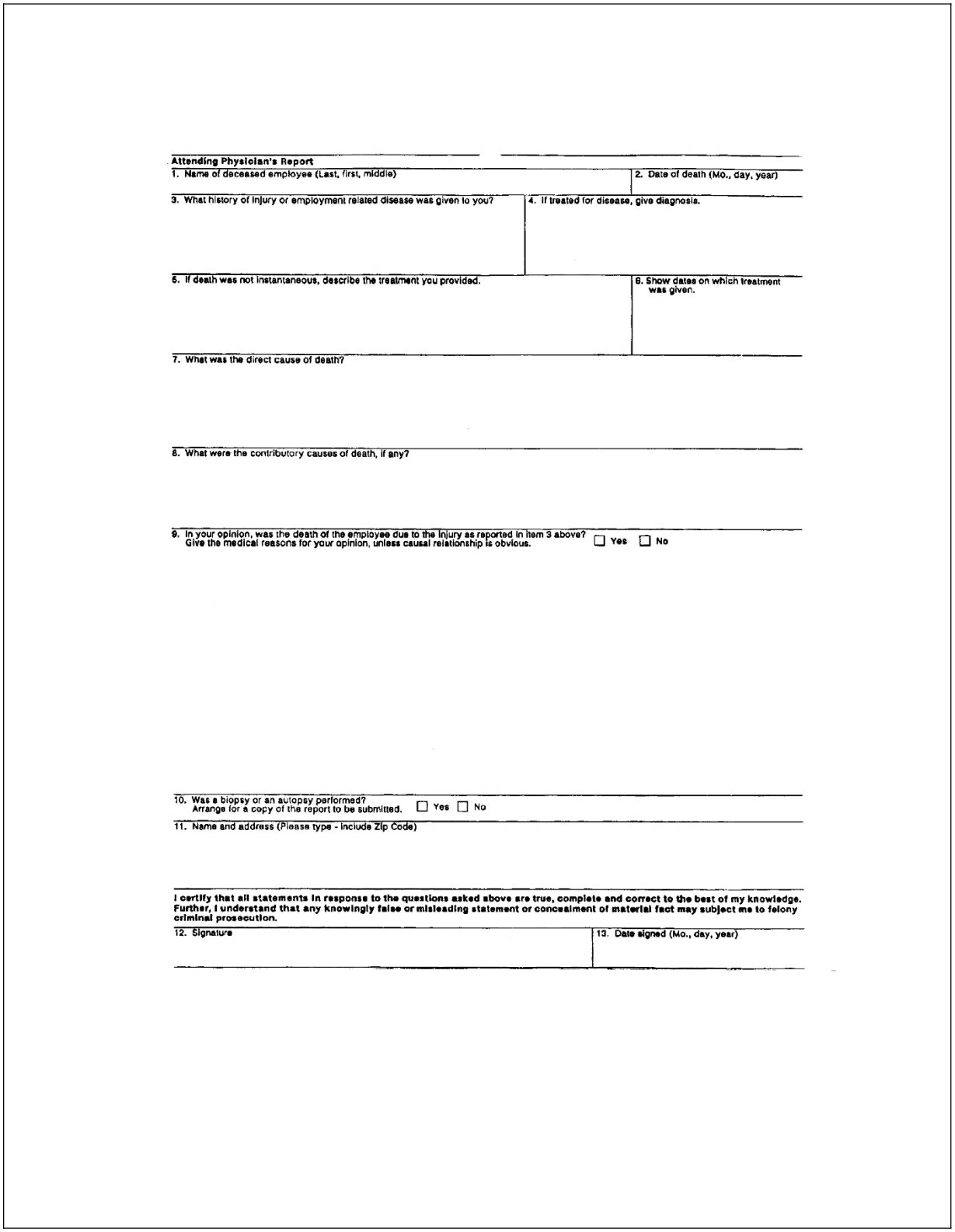
30. Total burial expense	31. Amount of burial expense paid or payable by VA	32. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid:
$ 6,500.00	$ None	Linda Perry Same As Above $6,500.00

I hereby certify that each and every statement made above is true to the best of my knowledge. 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 felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

33. Signature of person filing claim	34. Address (include Zip code)	35. Date (Mo., day, year)
Linda M. Sperry	110 Hunter Ave Anchorage, AK 99501	01-04-94

Form CA-5b

Figure 11. Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren," Continued



Attending Physician's Report

1. Name of deceased employee (Last, first, middle)
2. Date of death (Mo., day, year)
3. What history of injury or employment related disease was given to you?
4. If treated for disease, give diagnosis.
5. If death was not instantaneous, describe the treatment you provided.
6. Show dates on which treatment was given.
7. What was the direct cause of death?
8. What were the contributory causes of death, if any?
9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? ☐ Yes ☐ No
   Give the medical reasons for your opinion, unless causal relationship is obvious.
10. Was a biopsy or an autopsy performed? ☐ Yes ☐ No
    Arrange for a copy of the report to be submitted.
11. Name and address (Please type - include Zip Code)

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

12. Signature
13. Date signed (Mo., day, year)

Figure 11. Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren," Continued

INSTRUCTIONS FOR COMPLETING FORM CA-5b, CLAIM FOR COMPENSATION BY PARENTS, BROTHERS, SISTERS, GRANDPARENTS OR GRANDCHILDREN

Who Should File Claim	This claim form should be completed and filed by the deceased employee's parents, grandparents or representative (custodian or guardian) of minor brothers, sisters or grandchildren. A separate form is required for each person claiming benefits.
When Should Claim Be Filed	Claim must be filed within three years following date of death, unless the decedent's immediate superior had actual knowledge of an on-the-job injury or death within 30 days; or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.
What Documents Are Required	The birth certificate of the deceased employee; also a death certificate if not previously submitted; birth certificates for minor brothers, sisters and grandchildren. If claim is made on behalf of a grandparent, birth certificate of decedent's mother or father, as appropriate. If claim is made on behalf of a grandchild, birth certificate of decedent's son or daughter as appropriate. Copies of certificates or documents are acceptable only if they are certified by the person having official custody of such records. They should then be attached to the claim form when it is filed.
How to Complete Claim	All items on the claim form should be completed. If an item is not applicable, indicate by showing "NA". Note that the claim form requests information about several categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-20 the dependent; 21-25 the dependent's husband or wife, if married at the time of employee's death. The attending physician's report on the reverse of the form must also be completed before the form is submitted to the OWCP.
Funeral/Burial Allowance	Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0155), Washington, D.C. 20503.

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price

Figure 11. Form CA-5b, "Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren," Continued

DEATH BENEFITS FOR PARENTS, BROTHERS, SISTERS, GRANDPARENTS AND GRANDCHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Eligible Dependents	• Benefits are payable on behalf of partially or totally dependent parents, brothers, sisters, grandparents and grandchildren.
Period Of Entitlement	• Parents and grandparents: Payments continue until death, remarriage or termination of dependency. Minor brothers, sisters and grandchildren: Payments continue until death, marriage or attainment of 18 years of age. Payments may continue beyond 18 if the child is mentally or physically incapable of self-support or is a "full-time" student. Student benefits terminate on: marriage, completion of 4 years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	• For parent - 25% of the employee's monthly pay, if one is wholly dependent and the other is not dependent at all. If both are wholly dependent - 20% each. A proportionate amount is paid if either or both are partially dependent. Brothers, sisters, grandparents, and grandchildren - 20% if only one is wholly dependent. If more than one is wholly dependent - 30% shared equally. If one or more is partially dependent - 10% shared equally if more than one.
Payment Priorities	• Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly salary or 75% of the top step of GS-15 of the General Schedule. The surviving widow or widower and children have first priority. Other eligible dependents may receive payment only if the widow or widower and children's percentages are less than 75%.
Funeral/Burial Allowance	• Funeral and burial expense up to a maximum of $800 may be paid. Amount paid by the VA will be deducted. If death occurs away from the employee's duty station, transportation costs may be paid to return the deceased employee to his home or last place of residence. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	• If the employee's death was caused by a person or party other than the Federal Government, a "third party action" or lawsuit may be indicated. In such instances the Department of Labor will provide further instructions.

PRIVACY ACT

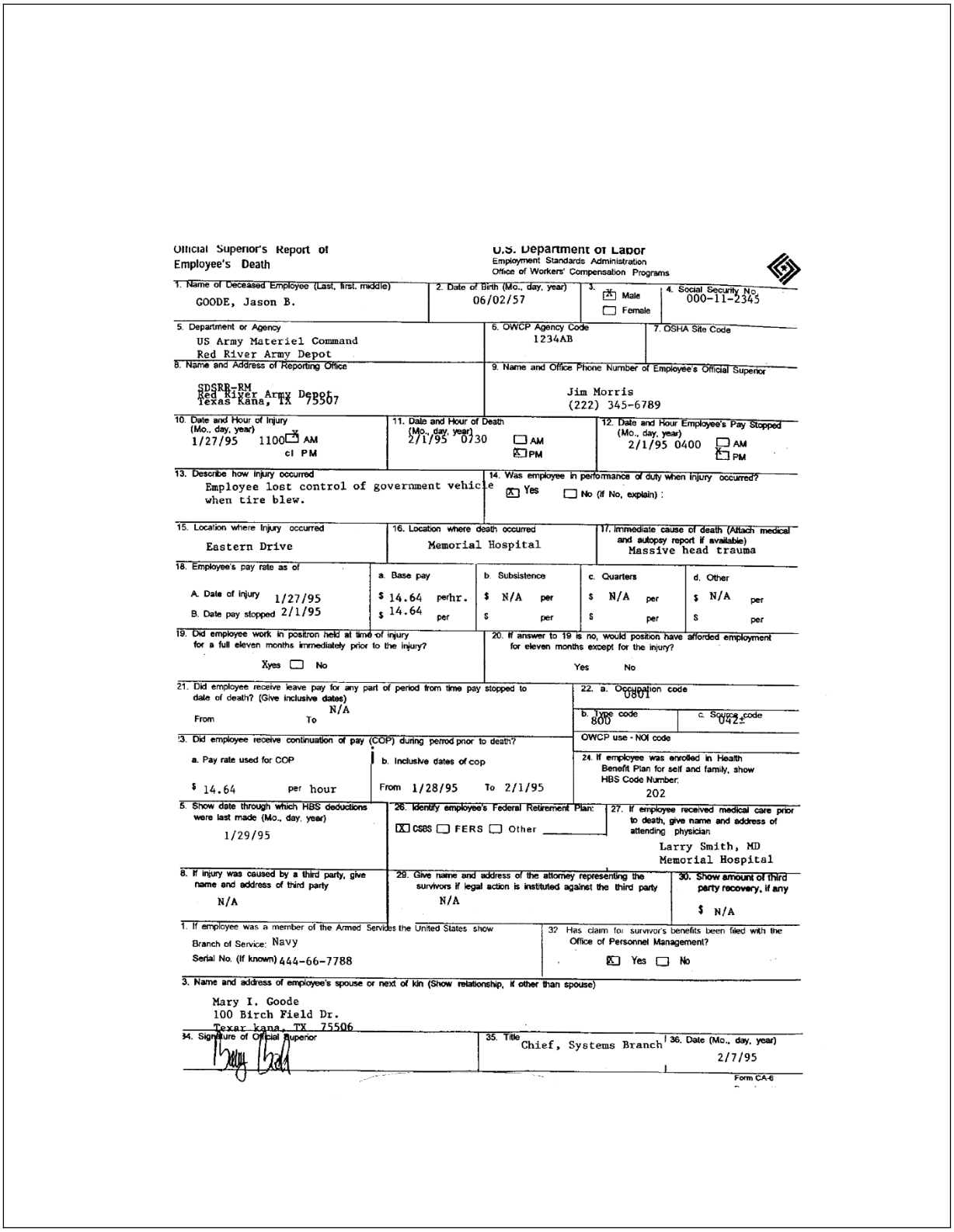
In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Form CA-5b
Rev. Mar. 1989

Figure 12. Form CA-6, "Official Superior's Report of Employee's Death," With Instructions



Official Superior's Report of Employee's Death

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

1. Name of Deceased Employee (Last, first, middle): GOODE, Jason B.
2. Date of Birth (Mo., day, year): 06/02/57
3. [X] Male [ ] Female
4. Social Security No.: 000-11-2345
5. Department or Agency: US Army Materiel Command, Red River Army Depot
6. OWCP Agency Code: 1234AB
7. OSHA Site Code:
8. Name and Address of Reporting Office: SDSRR-RM, Red River Army Depot, Texas Kana, TX 75507
9. Name and Office Phone Number of Employee's Official Superior: Jim Morris, (222) 345-6789
10. Date and Hour of Injury (Mo., day, year): 1/27/95 1100 [X] AM [ ] PM
11. Date and Hour of Death (Mo., day, year): 2/1/95 0730 [ ] AM [X] PM
12. Date and Hour Employee's Pay Stopped (Mo., day, year): 2/1/95 0400 [ ] AM [X] PM
13. Describe how injury occurred: Employee lost control of government vehicle when tire blew.
14. Was employee in performance of duty when injury occurred? [X] Yes [ ] No (If No, explain):
15. Location where injury occurred: Eastern Drive
16. Location where death occurred: Memorial Hospital
17. Immediate cause of death (Attach medical and autopsy report if available): Massive head trauma
18. Employee's pay rate as of
A. Date of injury 1/27/95
B. Date pay stopped 2/1/95

a. Base pay	b. Subsistence	c. Quarters	d. Other
$ 14.64 per hr.	$ N/A per	$ N/A per	$ N/A per
$ 14.64 per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? [X] Yes [ ] No
20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? Yes No
21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates) N/A From To
22. a. Occupation code: 0801
b. Type code: 800
c. Source code: 042
OWCP use - NOI code:
23. Did employee receive continuation of pay (COP) during period prior to death?
a. Pay rate used for COP: $ 14.64 per hour
b. Inclusive dates of cop: From 1/28/95 To 2/1/95
24. If employee was enrolled in Health Benefit Plan for self and family, show HBS Code Number: 202
25. Show date through which HBS deductions were last made (Mo., day, year): 1/29/95
26. Identify employee's Federal Retirement Plan: [X] CSRS [ ] FERS [ ] Other
27. If employee received medical care prior to death, give name and address of attending physician: Larry Smith, MD, Memorial Hospital
28. If injury was caused by a third party, give name and address of third party: N/A
29. Give name and address of the attorney representing the survivors if legal action is instituted against the third party: N/A
30. Show amount of third party recovery, if any: $ N/A
31. If employee was a member of the Armed Services the United States show
Branch of Service: Navy
Serial No. (If known) 444-66-7788
32. Has claim for survivor's benefits been filed with the Office of Personnel Management? [X] Yes [ ] No
33. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)
Mary I. Goode
100 Birch Field Dr.
Texar kana, TX 75506
34. Signature of Official Superior
35. Title: Chief, Systems Branch
36. Date (Mo., day, year): 2/7/95

Form CA-6

Figure 12. Form CA-6, "Official Superior's Report of Employee's Death," With Instructions, Continued

Instructions for Completing Form CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-I, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate. when submitted to OWCP.

Form CA-5 or CA-5b should be supplied to the employee's spouse or next of kin.

If additional space is required, attach separate sheets and number the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter 810, Injury Compensation, Federal Personnel Manual.

Box 22a (Occupation Code), Box 22b (Type Code), Box 22c (Source Code), OSHA She Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Figure 12. Form CA-6, "Official Superior's Report of Employee's Death," With Instructions, Continued

CPMS Instructions for Completing Form CA-6,
Official Superior's Report of Employee's Death

Item 1. Enter employee's last name, first name, and middle name (if no middle name, enter "NMN").

Items 2-4. Self-explanatory.

Item 3. Enter Army, Navy, Air Force, or appropriate activity.

Item 6. Enter activity chargeback code.emsp; (OWCP Agency Code)

Item 7. Enter OSHA Site Code.

Item 8. Enter name and address of servicing CPO/HRO.

Item 9. Self-explanatory.

Item 10. Enter month, day, year, and time of injury.

Item 11. Enter month, day, year, and time of death.

Item 12. Enter date and hour employee's pay stopped. If employee was in a duty status at the time of death, the remainder of date of death is charged to administrative leave.

Item 13. Enter detailed description of how injury occurred. Use attachment, if necessary.

Item 14. Check appropriate box. If checking "no," explain fully.

Item 15. Enter exact location of injury - specific work area.

Items 16-17. Self-explanatory.

Item 18. Enter employee's pay rate as of date of injury and date pay stopped.

Item 19. Check appropriate box.

Item 20. Enter "no" only if the employee was a temporary.

Item 21. Enter the beginning and ending dates of any annual or sick leave used. If time loss was intermittent, attach a list of dates lost and type leave taken.

Item 22. Enter occupation, type, and source codes.

Item 23. Self-explanatory.

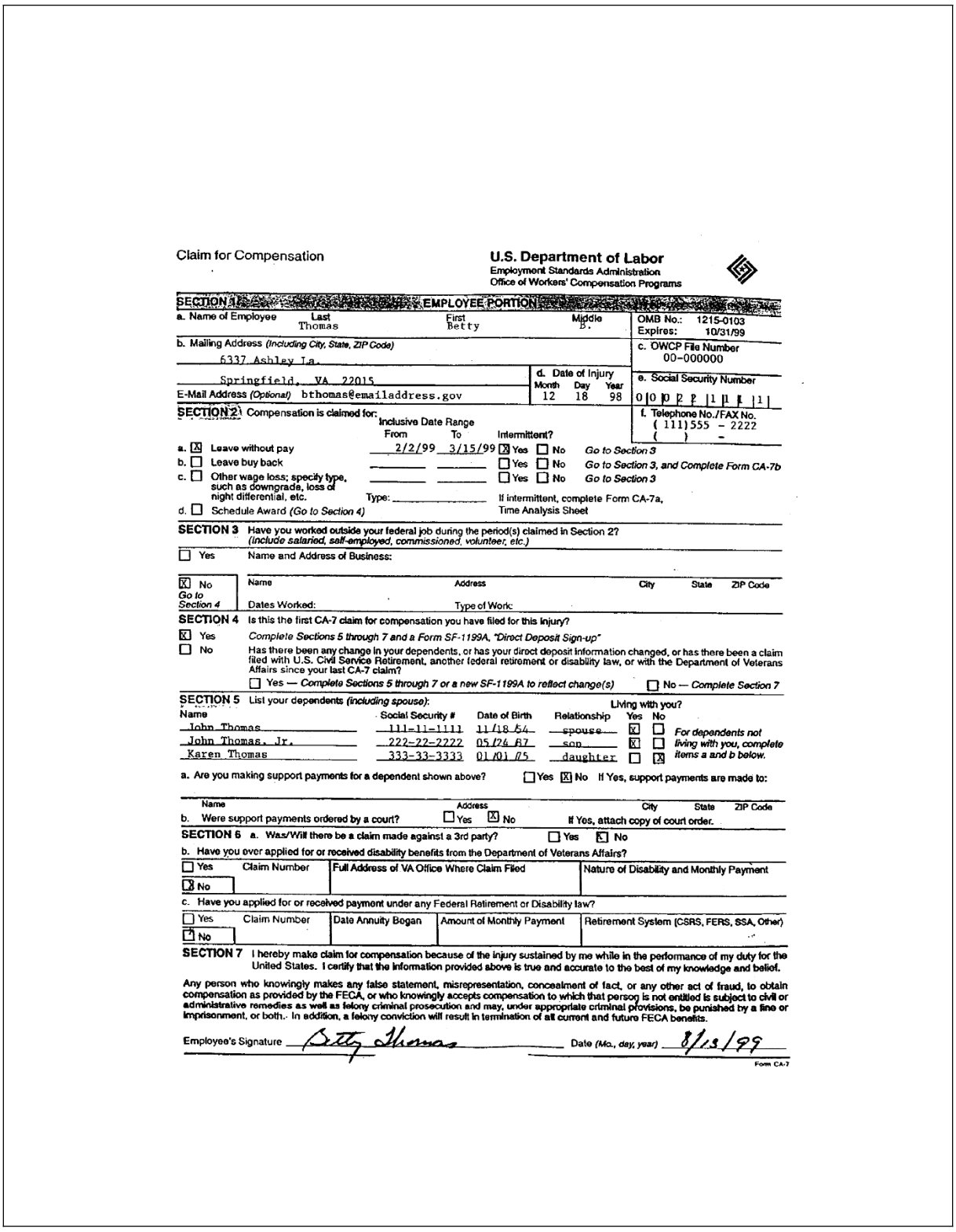
Items 24-25. Enter the health benefit plan code and the last day of the pay period in which health benefit deductions were made.

Item 26. Check appropriate block.

Item 27. Indicate full name and complete address, including ZIP code.

Items 28-36. Self-explanatory.

Figure 13. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Injury)



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: Thomas; First: Betty; Middle: B.

OMB No.: 1215-0103
Expires: 10/31/99

b. Mailing Address (Including City, State, ZIP Code)
6337 Ashley La.
Springfield, VA 22015
E-Mail Address (Optional) bthomas@emailaddress.gov

c. OWCP File Number: 00-000000

d. Date of Injury: Month 12, Day 18, Year 98

e. Social Security Number: 000-22-1111

f. Telephone No./FAX No.: (111) 555 - 2222

SECTION 2 Compensation is claimed for:

	Inclusive Date Range From	To	Intermittent?	
a. [X] Leave without pay	2/2/99	3/15/99	[X] 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 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commissioned, volunteer, etc.)

[ ] Yes — Name and Address of Business:

[X] 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?

[X] 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	
John Thomas	111-11-1111	11/18/64	spouse	[X]	[ ]	For dependents not living with you, complete items a and b below.
John Thomas, Jr.	222-22-2222	05/26/87	son	[X]	[ ]	
Karen Thomas	333-33-3333	01/01/75	daughter	[ ]	[X]	

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

Name | Address | City | State | ZIP Code

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

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

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

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

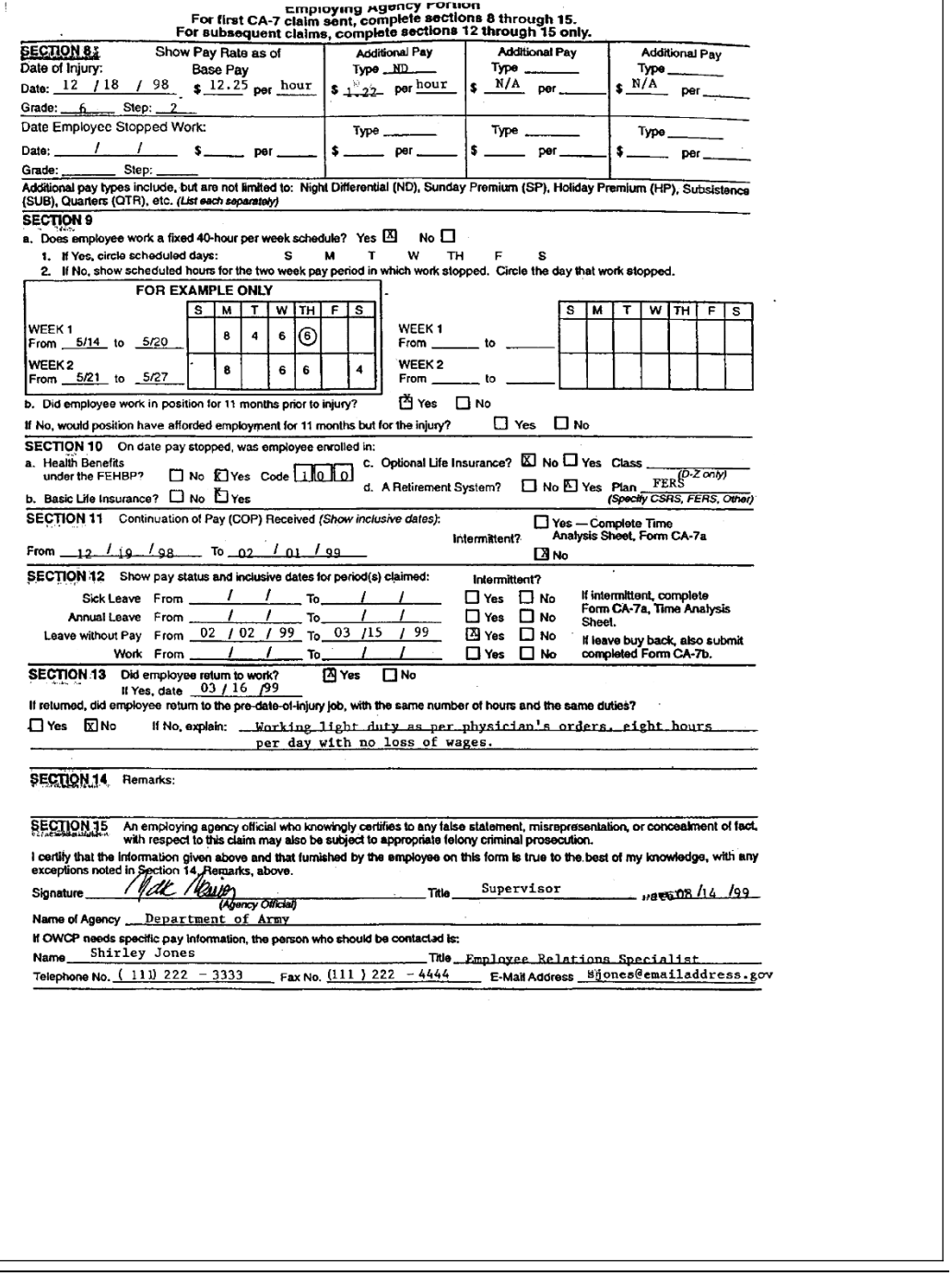
SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

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: Betty Thomas Date (Mo., day, year): 8/13/99

Form CA-7

Figure 13. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Injury), Continued



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
Date: 12 / 18 / 98 — $ 12.25 per hour
Grade: 6 Step: 2
Additional Pay: Type ND — $ 1.22 per hour
Additional Pay: Type ____ — $ N/A per ____
Additional Pay: Type ____ — $ N/A per ____
Date Employee Stopped Work: Date: / / — $ ____ per ____ — Grade: ____ Step: ____
Type ____ — $ ____ per ____ (×3)
Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarters (QTR), etc. *(List each separately)*

SECTION 9
a. Does employee work a fixed 40-hour per week schedule? Yes [X] 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 2 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? [X] 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 [X] Yes Code 1 0 0
b. Basic Life Insurance? [ ] No [X] Yes
c. Optional Life Insurance? [X] No [ ] Yes Class ____ (D-Z only)
d. A Retirement System? [ ] No [X] Yes Plan FERS (Specify CSRS, FERS, Other)

SECTION 11 Continuation of Pay (COP) Received *(Show inclusive dates)*:
From 12 / 19 / 98 To 02 / 01 / 99
Intermittent? [ ] Yes — Complete Time Analysis Sheet, Form CA-7a [X] No

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

	From	To	Intermittent?
Sick Leave	/ /	/ /	[ ] Yes [ ] No
Annual Leave	/ /	/ /	[ ] Yes [ ] No
Leave without Pay	02 / 02 / 99	03 / 15 / 99	[X] Yes [ ] No
Work	/ /	/ /	[ ] Yes [ ] No

If intermittent, complete Form CA-7a, Time Analysis Sheet.
If leave buy back, also submit completed Form CA-7b.

SECTION 13 Did employee return to work? [X] Yes [ ] No
If Yes, date 03 / 16 / 99
If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?
[ ] Yes [X] No If No, explain: Working light duty as per physician's orders, eight hours per day with no loss of wages.

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 [signature] (Agency Official) Title Supervisor Date 03/14/99
Name of Agency Department of Army
If OWCP needs specific pay information, the person who should be contacted is:
Name Shirley Jones Title Employee Relations Specialist
Telephone No. (111) 222 - 3333 Fax No. (111) 222 - 4444 E-Mail Address sjones@emailaddress.gov

Figure 13. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Injury), Continued

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

EMPLOYEE (or person acting on the employee's behalf) — Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) — Complete sections 8 through 15 as directed and promptly forward the form to OWCP.

EXPLANATIONS — Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

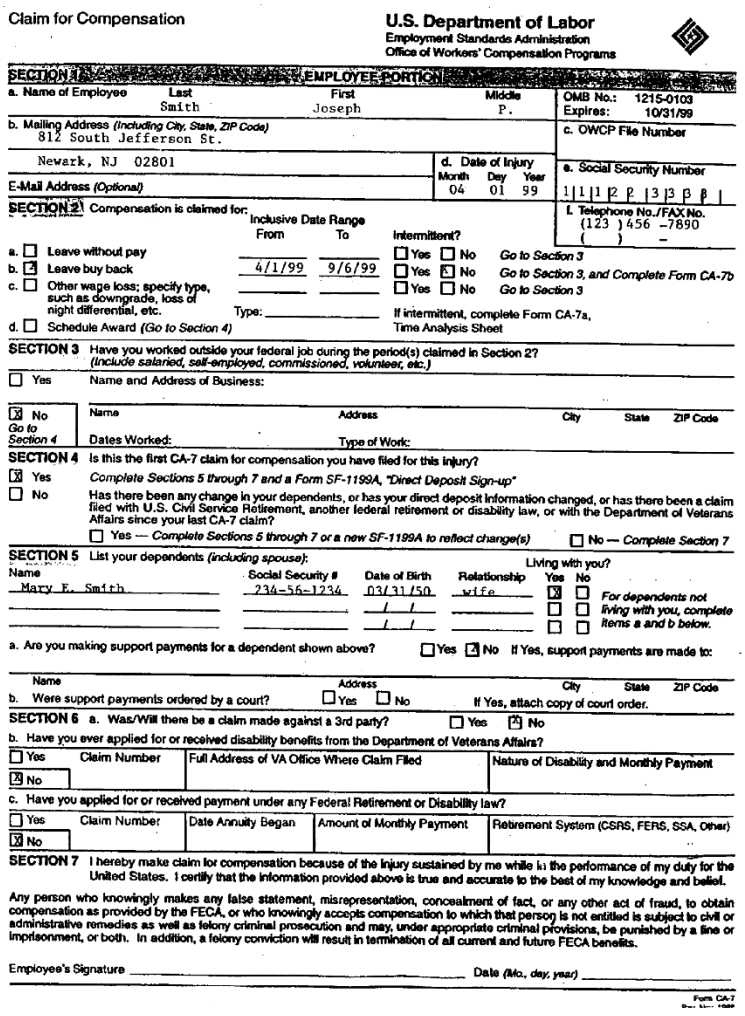
Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the 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 this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

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

Figure 14. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Disease)



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: Smith; First: Joseph; Middle: P.

OMB No.: 1215-0103
Expires: 10/31/99

b. Mailing Address (Including City, State, ZIP Code): 812 South Jefferson St., Newark, NJ 02801

c. OWCP File Number

d. Date of Injury: Month 04 Day 01 Year 99

e. Social Security Number: 111 22 3333

E-Mail Address (Optional)

f. Telephone No./FAX No.: (123) 456-7890

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	4/1/99	9/6/99	☐ 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 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commissioned, volunteer, etc.)

☐ 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
Mary E. Smith	234-56-1234	03/31/50	wife	☒	☐
		/ /		☐	☐
		/ /		☐	☐

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?

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

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

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

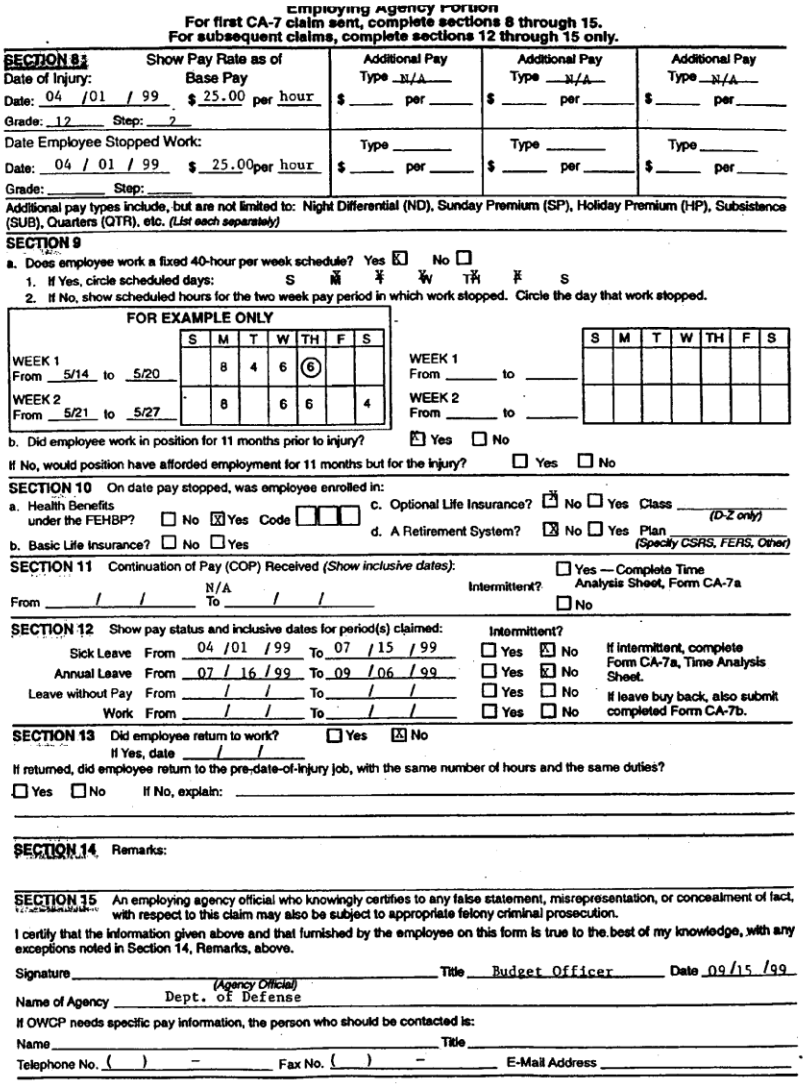
SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

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

Figure 14. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Disease), Continued



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: 04 /01 / 99	$ 25.00 per hour	Type N/A $ ____ per ____	Type N/A $ ____ per ____	Type N/A $ ____ per ____
Grade: 12 Step: 2				
Date Employee Stopped Work:		Type ____	Type ____	Type ____
Date: 04 / 01 / 99	$ 25.00 per hour	$ ____ per ____	$ ____ per ____	$ ____ per ____
Grade: ____ Step: ____				

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

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? Yes [X] 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 2 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? [X] 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 [X] Yes Code [ ][ ][ ]
b. Basic Life Insurance? [ ] No [ ] Yes
c. Optional Life Insurance? [X] No [ ] Yes Class ____ *(D-Z only)*
d. A Retirement System? [X] No [ ] Yes Plan ____ *(Specify CSRS, FERS, Other)*

SECTION 11 Continuation of Pay (COP) Received *(Show inclusive dates)*:
From ____/____/____ To N/A ____/____/____
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 04 /01 /99 To 07 /15 /99	[ ] Yes [X] No	If intermittent, complete Form CA-7a, Time Analysis Sheet.
Annual Leave	From 07 / 16 /99 To 09 /06 /99	[ ] Yes [X] 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 [X] 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 ____ *(Agency Official)* Title Budget Officer Date 09/15/99
Name of Agency Dept. of Defense
If OWCP needs specific pay information, the person who should be contacted is:
Name ____ Title ____
Telephone No. ( ) – Fax No. ( ) – E-Mail Address ____

Figure 14. Form CA-7, "Claim for Compensation on Account of Traumatic Injury or Occupational Disease," With Attached Form CA-20, "Attending Physician's Report" (Example of CA-7 for Occupational Disease), Continued

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

EMPLOYEE (or person acting on the employee's behalf) — Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) — Complete sections 8 through 15 as directed and promptly forward the form to OWCP.

EXPLANATIONS — Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
3a. Was/will there be a claim made against 3rd party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

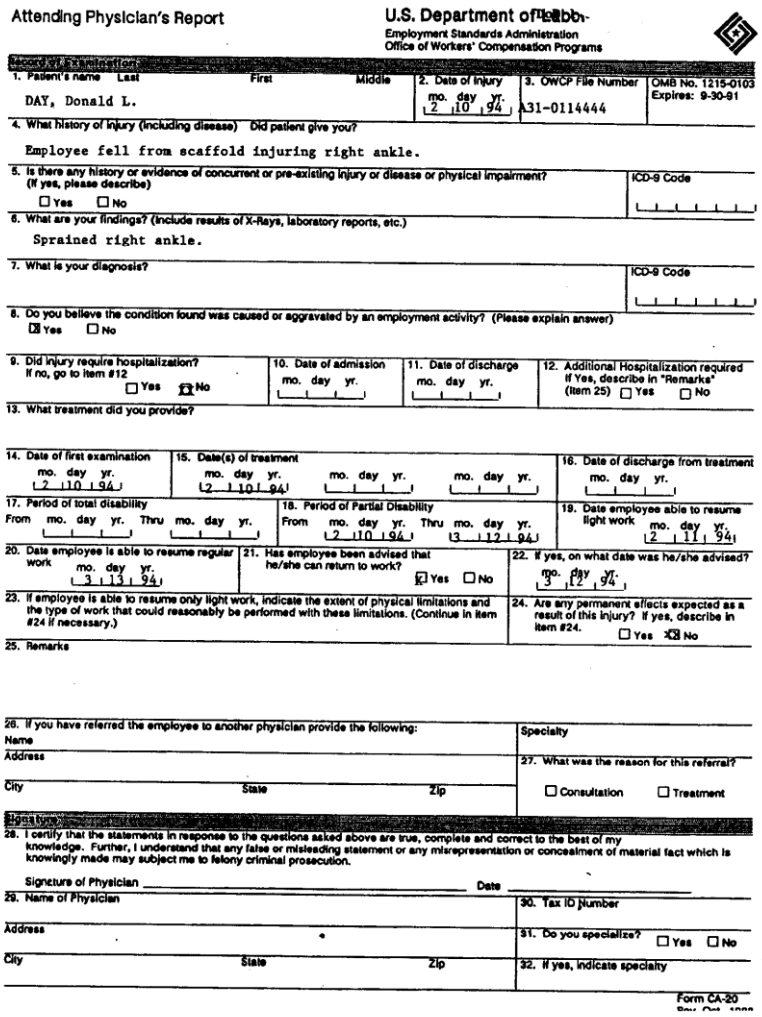
Public Burden Statement

ublic reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching isting data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments garding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department f Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

O *NOT* SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Figure 15. Form CA-20, "Attending Physician's Report"



Attending Physician's Report

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

Medical Examination

1. Patient's name Last First Middle: DAY, Donald L.
2. Date of injury: 2 10 94
3. OWCP File Number: A31-0114444
OMB No. 1215-0103 Expires: 9-30-91

4. What history of injury (including disease) Did patient give you?: Employee fell from scaffold injuring right ankle.

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.): Sprained right ankle.

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 #12 ☐ 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: 2 10 94
15. Date(s) of treatment: 2 10 94
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 2 10 94 Thru 3 12 94
19. Date employee able to resume light work: 2 11 94

20. Date employee is able to resume regular work: 3 13 94
21. Has employee been advised that he/she can return to work? ☒ Yes ☐ No
22. If yes, on what date was he/she advised? 3 12 94

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 #24 if necessary.)
24. Are any permanent effects expected as a result of this injury? If yes, describe in item #24. ☐ Yes ☒ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State Zip
Specialty
27. What was the reason for this referral? ☐ 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 statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ 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

Figure 15. Form CA-20, "Attending Physician's Report," Continued

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.

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 1-31 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 16; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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Washington, DC 20402

*U.S. Government Printing Office: 1991 — 528-172

Figure 15. Form CA-20, "Attending Physician's Report," Continued

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 19 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 20 through 37 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter inclusive dates covering the period for which you are claiming compensation. If intermittent periods are claimed, use a separate sheet to list each period individually.
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured; and pay for work actually performed, whether at the Federal job in which you were injured or at other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
8) Was Claim Made Against 3rd Party?	A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
13) List Your Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
21) If Employee Received Additional Pay, Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
28) Type and Inclusive Dates Employee Received Leave for Any Part of Period Since Stopping Work	Enter inclusive dates covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day; if the number of hours used per day varied, use a separate sheet to list each day.
29) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for a full explanation). If the injury was not a traumatic injury reported on form CA-1, this item does not apply.
30) Date All Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status; therefore, item 30 refers to termination of all pay, including leave. Compensation is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

Figure 15. Form CA-20, "Attending Physician's Report," Continued

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

Figure 16. Instructions for Completing Form CA-7

Instructions for Completing Form CA-7, Claim for, Compensation on Account of Traumatic Injury or Occupational Disease with CA-20, Attending Physicians Report

PART A. The employee or employee's representative completes Items 1 through 19.

Employees:

Item 1. Enter your last name, first name, and middle name (if no middle name, enter "NMN").

Items 2-3. Self-explanatory.

Item 4. Enter beginning and ending dates of time lost due to injury and hours claimed. If claiming schedule award, enter "NA."

Item 5. If the injury has resulted in a permanent loss of some part of the body or partial loss of function of some part of the body, enter "yes." The OWCP will base the schedule award on the percentage of impairment. Refer to Section 8107 of the FECA for compensation schedule.

Item 6. Self-explanatory.

Item 7. Enter total amount and the period covered.

Item 8. Check appropriate box. Complete a. or b., if applicable.

Item 9. If yes, provide complete address, including 9-digit ZIP code.

Item 10. Self-explanatory.

Item 11. Self-explantory.

Item 12. Check appropriate box. If yes, provide information requested in a., b., and c.

Item 13. Check appropriate box. If yes, provide information requested in a., b., and c.

Item 14. List all relatives (including adopted children) who depend on you for support. A spouse living with you is considered a dependent whether or not he or she is financially dependent on you.

Items 15-16. Self-explanatory.

Item 17. List to whom support payments are made.

Item 18. Indicate amount paid out for each dependent and the frequency of payments.

Figure 16. Instructions for Completing Form CA-7, Continued

Items 19-20. Self-explanatory.

PART B. The supervisor completes Items 20 through 37. Supervisors:

Item 21. Enter pay rate as of the date of injury and as of the date employee stopped work.

Item 22. If applicable, obtain premium pay from payroll for one year before DOI. If information is not readily available, indicate that premium pay has been requested and will be forwarded upon receipt.

Item 23. Indicate the scheduled workdays for the week in which pay stopped. Enter "NA" if pay has not stpopped.

Item 24. Check appropriate box.

Item 25. Enter "no" only if a temporarty employee.

Item 26. Include all Federal civilian service.

Items 27-28. Self-explanatory.

Item 29.

a. Enter the beginning and ending dates of any annual or sick leave used. If time was intermittent, attach a list of dates lost and type of leave taken.

b. Enter any dates the employee received holiday pay, administrative leave or any paid leave category other than sick or annual leave.

Item 30. Enter the period or periods the employee received COP, including nonduty days and holidays if the period of COP spans such days.

Item 31. Enter month, date, year and time employee's pay stopped.

Item 32. Enter beginning and ending dates for which compensation is claimed.

Item 33. Enter month, date, year and time employee returned to work.

Item 34. Indicate work schedule when employee returned to work.

Item 35. If employee has returned to a light-duty assignment or other assignment as a result of the injury, describe the specific functions employee is performing.

Item 36. Enter pay rate of employee upon return to work.

Items 37-38. Self-explanatory.

NOTE: If not previously submitted, attach a copy of position description and physical requirements (SF 78) for the job held on DOI and Application for Employment from the OPF.

Special Note: CA-20 should be attached to Form CA-7 to support claim being made.

Figure 16. Instructions for Completing Form CA-7, Continued

CPMS Instructions for Completing Form CA-7, Claim for, Compensation on Account of Traumatic Injury or Occupational Disease with CA-20, Attending Physicians Report

The employee or the employee's representative fills out Items 1 through 7.

SECTION 1.

Item a. Enter last name, first name, and middle name (if no middle name, enter "NMN").

Item b. Enter complete mailing address, and email address, if appropriate. Note that email address is optional.

Items c-f. Self-explanatory.

SECTION 2.

Select appropriate items a-d to indicate nature of claim. Indicate beginning and ending dates of all time lost for each of selected items a-c. If intermittent time is claimed, complete Form CA-7a, "Time Analysis Sheet," indicating comprehensive listing of all dates and hours of lost time. If injury has resulted in a permanent loss of function of some part or the body, select item d. OWCP will base any potential schedule award entitlement on the percentage of permanent impairment. Refer to Section 8107 of the FECA for the compensation schedule.

SECTION 3.

List all gainful employment including salaried positions, self-employment, volunteer work, etc., for the period(s) claimed in item 2. Include name and address of business, dates and times worked, and a description of the work completed.

SECTION 4.

Check appropriate block. If this is the first Form CA-7 filed, if there has been a change in dependent status or direct deposit information, or if another Federal disability or retirement claim has been filed since the last Form CA-7, complete items 5-7. If not, go directly to section 7.

SECTION 5.

List all dependents (including adopted children) names, social security numbers, dates of birth, and family relationship, and indicate whether the dependent(s) lives with you. If not, go to items a and b.

Item a. Check appropriate block and indicate to whom support payments are made, if applicable.

Figure 16. Instructions for Completing Form CA-7, Continued

Item b. Check appropriate box and include copy of court order, if applicable.

SECTION 6.

Item a. Self-explanatory.

Item b. Check appropriate block and indicate information about VA disability claim, if applicable.

Item c. Check appropriate block and include information about retirement or disability payments, if applicable.

SECTION 7.

Self-explanatory.

The supervisor completes sections 8 through 15.

SECTION 8.

Enter base pay rate at the time of the injury as well as the date employee stopped work (if different), and include any applicable premium pay for the year prior to the date of injury. If premium pay information is not readily available from payroll, indicate that information regarding premium pay has been requested and is forthcoming.

SECTION 9.

Item a. Check appropriate block. If "yes," circle scheduled days. If "no," complete chart showing scheduled hours during the pay period when employee stopped work.

Item b. Check appropriate block(s).

SECTION 10.

Check appropriate blocks for items a-d, and include requested information, where applicable.

SECTION 11. Self-explanatory.

Include all dates that COP was received. If intermittent, include Form CA-7a, "Time Analysis Sheet," showing a day-by-day breakdown for all COP used.

SECTION 12.

Enter beginning and ending dates for all time lost from work, in each appropriate category. If intermittent time is being claimed, complete Form CA-7a and include a comprehensive day-by-day breakdown for all time lost.

Figure 16. Instructions for Completing Form CA-7, Continued

SECTION 13.

Indicate whether the employee has returned to duty. If yes, include the date. If the employee has not returned to full, unrestricted duty, describe his or her current duty status.

SECTION 14.

Include any other comments or remarks.

SECTION 15.

Self-explanatory.

Figure 17. Sample Letter to Physician Forwarding Form CA-16

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB

SUBJECT: Federal Employees Injured at Work

TO: Amos B. Jackson, M.D.
Street Address
City, State Zip Code

Dear Dr. Jackson:

Our employee, James O. Smith, has sustained a job-related traumatic injury on 25 May 1994, which may entitle him to benefits under the Federal Employees' Compensation Act.

Before the Office of Workers' Compensation Programs (OWCP) can make a decision on the claim, they must have comprehensive medical evidence from the physician providing treatment for the injury. Accordingly, we request that you complete the enclosed form and give it to our injured employee when you have finished your examination. A medical release form has been completed by our injured employee and is forwarded for your retention.

We are willing to accommodate partially disabled employees with suitable light- or limited-duty assignments. We can and will provide light- or limited-duty assignments in strict accordance with any physical limitations you impose. If you feel the employee cannot perform any type of work, please send us a prognosis of when return to work may be possible in either a limited or full capacity.

Please submit your bill on the enclosed billing form HCFA-1500 and return it in the self-addressed envelope.

Figure 17. Sample Letter to Physician Forwarding Form CA-16, Continued

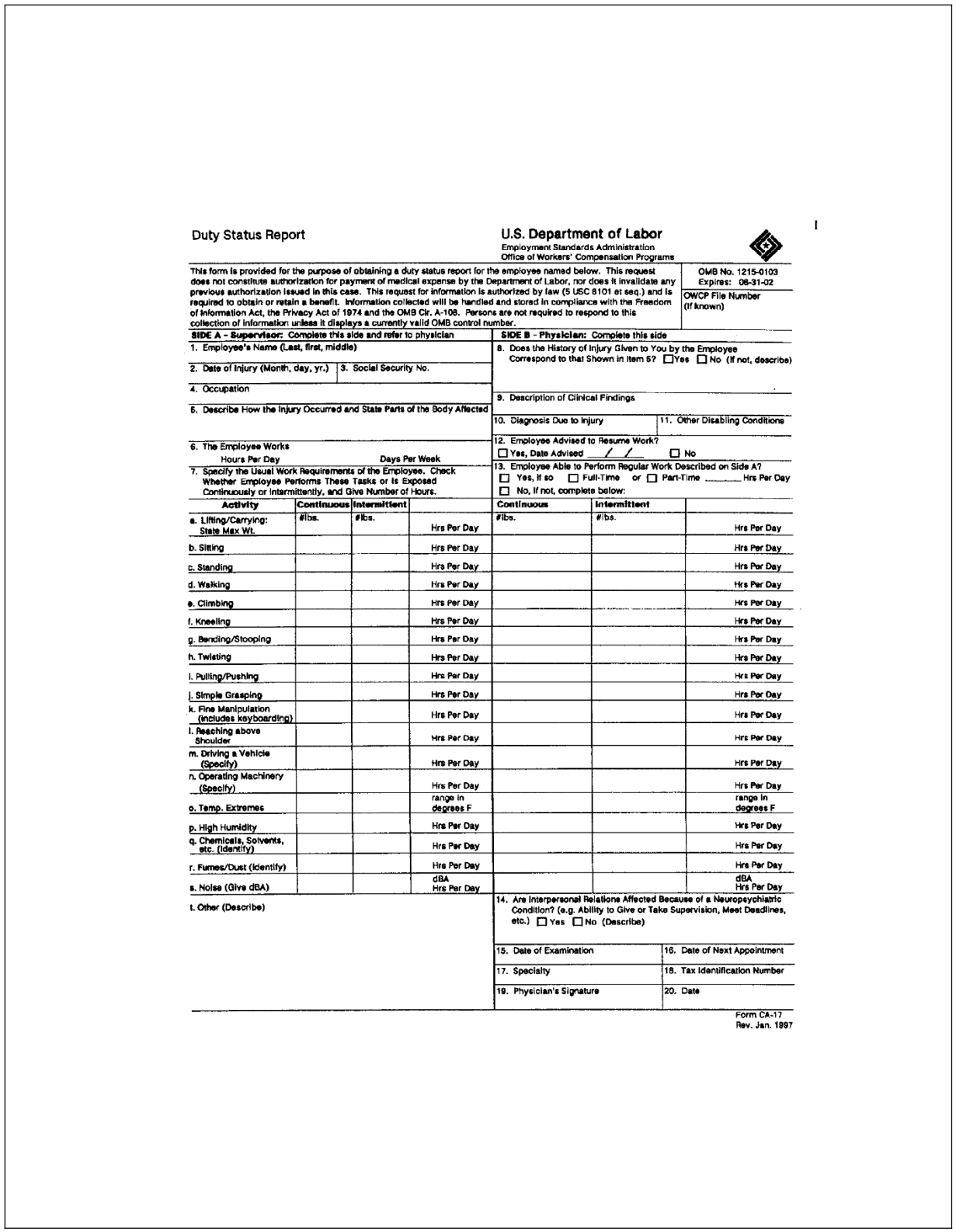
Thank you for your time and cooperation. If I can be of any assistance, please call me at 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-16
2. HCFA-1500 w/Envelope
3. Med Release

Figure 18. Form CA-17 "Duty Status Report," With Instructions



Duty Status Report

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: 08-31-02

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.

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

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:

	Continuous	Intermittent	
	#lbs.	#lbs.	Hrs Per Day
			Hrs Per Day
			Hrs Per Day
			Hrs Per Day
			Hrs Per Day
			Hrs Per Day
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			Hrs Per Day
			Hrs Per Day
			range in degrees F
			Hrs Per Day
			Hrs Per Day
			Hrs Per Day
			dBA Hrs Per Day

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

Figure 18. Form CA-17 "Duty Status Report," With Instructions, Continued

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the OWCP, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

Figure 18. Form CA-17 "Duty Status Report," With Instructions, Continued

Instructions for Completing Form CA-17

Side A - Supervisor. The issuing official (supervisor or installation medical facility official) completes Items 1 through 7.

Item 1. Enter the employee's last name, first name, middle name (enter "NMN" if no middle name).

Item 2. Enter the date of original injury. See Item 10 on the Form CA-1 or Item 12 on the Form CA-2 if an occupational disease.

Item 3. Self-explanatory.

Item 4. Enter the employee's position title.

Item 5. See Items 13 and 14 on the Form CA-1 if a traumatic injury, or Item 14 on the Form CA-2 if an occupational disease.

Item 6. Self Explanatory.

Item 7. Indicate the physical requirements of the employee's actual duties.

Reverse - Supervisor completes the three address blocks.

Block 1. Enter the name and complete address of the authorized treating physician.

Block 2. Enter the name and complete address of the servicing civilian personnel office.

Block 3. Enter the complete address of the OWCP office.

Part B. The attending physician completes Items 8 through 20.

A physician's assistant, nurse, practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. However, certification by a physician's assistant will be acceptable if such certification is counter-signed by a physician.

Figure 19. Sample Letter to Physician Forwarding Form CA-17

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Federal Employees Injured at Work

TO: Amos B. Jackson, M.D.
Street Address
City, State Zip Code

Dear Dr. Jackson:

Our employee, James O. Smith, has elected treatment from you due to a claim of work-related injury. The purpose of this letter is to advise you of our willingness to accommodate partially disabled employees with suitable light- or limited-duty assignments. We can and will provide light- or limited-duty assignments in strict accordance with any physical limitations you impose.

In this regard, please complete the attached Form CA-17, "Duty Status Report," and return the form in the self-addressed envelope provided. If you find that Mr. Smith is unable to return to his usual job, but can return to work in a limited-duty status, please indicate his physical restrictions on the Form CA-17 so we can temporarily reengineer his job assignment to meet these physical restrictions. Limited duty can be as light and sedentary as answering telephones four to eight hours a day or other routine clerical work at a desk.

If you wish to discuss this case or have any questions, please call our Injury Compensation Specialist, _____ at 522-0001 or _____ MD, Base Civilian Dispensary at 522-0002.

Figure 19. Sample Letter to Physician Forwarding Form CA-17, Continued

We thank you for your assistance.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

1 Encl
Form CA-17 w/envelope

cc: SGP

Figure 20. Letter to Physician Requesting Duty Status on Long-Term Claimant

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Duty Status Report - John J. Jones, A00-1111111

TO: Amos B. Jackson, M.D.
Street Address
City, State Zip Code

Dear Dr. Jackson:

Our records show Mr. Jones has been off work since 13 March 1993 and under your care for a back injury that occurred on 10 March 1993. We are interested in rehabilitating our employees and would appreciate a work evaluation about what type of work Mr. Jones can do and for how many hours a day.

We support rehabilitation and recognize the benefits to the patient, the family, and the employer. We have found that without rehabilitation, employees on a total disability status become entrenched in a "disability rut" with no motivation or reason to rehabilitate themselves to return to work. In some situations, employees perform more strenuous and physically demanding activities while off work than the light duty we have available.

Through our rehabilitation program, we provide suitable light- or limited-duty assignments for our employees who are partially disabled from on-the-job injuries. We will cooperate with you in providing the light-duty assignments. If Mr. Jones is not able to return to his former position, we can provide light sedentary work for as little as four hours a day.

Often, we find that there is a great deal of misunderstanding between workers' compensation and disability retirement. In case you are not clear on the two programs, a definition of workers' compensation and retirement is enclosed.

Figure 20. Letter to Physician Requesting Duty Status on Long-Term Claimant, Continued

Please carefully consider Mr. Jones' disability, and his ability to perform some type of work, either in a part- or full-time capacity. Your evaluation should be based on objective findings of disability rather than subjective complaints. We will accommodate any limitations you impose. If he cannot return to work at this time, please give us a prognosis about when he can probably work in a light-duty capacity.

If you have any questions, please call me at (692) 222-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

Encl
1. Definition
2. Form CA-17 w/envelope

cc: OWCP
SGP

Figure 21. Sample Letter on Light Duty on Current Employee

USE INSTALLATION LETTERHEAD

FROM: AAAA-CC Date

SUBJECT: Light-Duty Assignment for Mr. Ivan A. Green, Claim No. A00-000000 (If Known)

TO: Mr. Ivan A. Green
Street Address
City, State Zip Code

Dear Mr. Green:

1. This letter confirms our conversation on 1 February 1994 in which you were: (a) offered a light-duty assignment, the duties of which conform to the physical limitations established by Dr. A. B. White, who is treating you for your on-the-job injury of 5 January 1994; and (b) advised that if you do not accept this light-duty assignment, you will be considered AWOL and, you will not be entitled to continuation of pay.

2. Following is a list of duties and the physical requirements of those duties you will be performing white on light duty during the period 9 February through 4 March 1994, in the Packing Section of Warehouse B at Defense Distribution Region East (Memphis):

a. While sitting or standing, break down large packages of small items into small packages and place identifying labels on small packages. No lifting over 10 pounds or bending is required. Large boxes are brought to work area on a computer controlled conveyor system that provides for off-loading onto a platform that can be raised or lowered to convenient work height. Small packages are placed in boxes and removed by the conveyor system. Standing surfaces are covered with special fatigue mats. Chairs are designed to accommodate people with back injuries. As desired, work benches can be raised or lowered to accommodate sitting or standing working positions.

Figure 21. Sample Letter on Light Duty on Current Employee, Continued

b. Per Dr. White's instructions, you are not to lift more than 10 pounds during the light-duty period. You may take extra breaks as needed.

3. The hours of work will be from 0800 to 1630 hours. You must respond to this offer no later than five days from the date of this letter. A copy of this letter will be provided to the Office of Workers' Compensation Programs (OWCP).

Sincerely,

James L. Smith
Chief, Warehouse B

cc: HRO (M. Brown)
OWCP

Figure 22. Hearing Loss Checklist

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

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

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

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

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

Form CA-35B
Rev. Aug. 1988

Figure 22. Hearing Loss Checklist, Continued

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 23. Sample Hearing Loss Claim

SAMPLE HEARING LOSS CLAIM - VEHICLE OPERATOR SUMMARY

Mr. Jackson is a 60-year old employee who has claimed a job-related hearing loss. He alleges frequent exposure to hazardous noise while employed as a Vehicle Operator for a 9-year period.

CLAIMANT'S STATEMENT

I work as a Vehicle Operator in the Transportation Squadron and have been working out of Base Operations on the flightline for nine years.

We have many transient KC 135 aircraft coming from other bases and that land here and unload and load personnel without shutting their engines off. This makes a lot of noise and we take personnel to within approximately 50 feet of the aircraft to exchange personnel. Also, our own base KC 135 aircraft on training missions change crews many times without shutting down engines. The frequency of these changes varies, but will average five or more times per week.

SUPERVISOR'S STATEMENT

1. I have been Mr. Jackson's supervisor for the past four years in his position as Vehicle Operator.

2. Essentially, Mr. Jackson's statement of his duties is accurate. However, I do not believe that the performance of those duties contributed to his alleged hearing difficulties. Personnel changes take less than 10 minutes each, from start to finish, and hearing protection is provided. Mr. Jackson is involved in an average of 15 to 20 changes a day. The rest of the time, the drivers sit inside in a lounge-type environment and watch TV, play cards, and talk among themselves.

3. Drivers are prohibited from being within 50 feet of aircraft when engines are running which at most is 10 percent of the time.

4. Drivers simply deliver passengers from the terminal to the aircraft and return to the terminal. Normally, they do not leave the bus.

Figure 23. Sample Hearing Loss Claim, Continued

5. Hearing protection includes ear plugs that were issued and fitted by the base clinic. Mr. Jackson has had his ear plugs since his first day of employment as a Vehicle Operator. He regularly wears his hearing protection. All employees have been counseled regarding proper procedures for wearing hearing protection. Mr. Jackson was in attendance when counseling was provided on the following dates:

16 February 1986
23 March 1987
12 January 1988
l March 1989
2 April 1990
13 February 1991
20 March 1992

Mr. Jackson and I both take sound safety practices seriously and to my knowledge he has never been observed or known to work without wearing his ear plugs when his duty so required.

6. Mr. Jackson retired from the Air Force (military) before his employment here. Additionally, he plays in a band on weekends and is a voluntary firefighter in his community. It appears that these factors may have contributed to his hearing problems if, in fact, they are noise related.

Figure 24. Sample Employee's Supplemental Statement to Hearing Loss Claim

EMPLOYEE'S SUPPLEMENTAL STATEMENT
TO LOSS OF HEARING CLAIM

1. NAME:

2. Date you first became aware of hearing problem:

3. Date you first related that problem to your Federal employment and why:

4. If no longer exposed to noise, indicate date of last exposure:

5. Give a detailed history of any previous ear or hearing problems and provide any medical reports or audiograms you may have:

6. Describe in detail the duties you performed that you believe contributed to your hearing problems:

7. State when safety devices were provided and the type:

8. Did you wear the safety devices at all times as required:

9. Describe and/or diagram the work site and placement of any equipment that you believe contributed to your hearing problems:

10. List all hobbies or activities in which you participate such as hunting, dirt bikes, boating, farming, motorcycles, auto mechanics, carpentry work, cutting and polishing rocks, body work on cars, three or four wheeling, etc. Describe how often you participate in these activities and the number of days:

11. List the names of others who worked in the same area(s) and who had hearing loss:

Figure 24. Sample Employee's Supplemental Statement to Hearing Loss Claim, Continued

12. If you were in the military service, list your job title(s) and inclusive dates you served. If you worked in a noise area, describe the source of noise and number of hours of exposure per day, and describe the hearing protectors provided to protect against noise exposure:

13. Did you wear the hearing protectors?

14. Attach statements from co-workers who have first-hand knowledge of your working and/or physical conditions.

15. Provide any other information you believe is pertinent to this claim.

16. I certify that the information provided is true.

_____ _____

Signature Date

Figure 24. Sample Employee's Supplemental Statement to Hearing Loss Claim, Continued

SUPERVISOR'S SUPPLEMENTAL STATEMENT TO HEARING LOSS CLAIM

1. Claimant's Name:

2. Time Frame (list dates employee worked in your area):

3. Description of Duties (describe in detail the work performed by the employee and provide a copy of the position description):

4. Working Conditions (identify all sources of noise; such as drills, compressors, rivet guns, etc.):

5. Safety Precautions (describe equipment or procedures used to reduce the hazard, e.g., whether hearing protection is required, and type worn): Did the employee wear the hearing protection as required by regulations?

6. Work Exposure (state the nature, extent and duration of exposure, including dates, hours per day and days per week):

7. Description and/or diagram of work site (list all buildings employee worked in, describe the work site(s) and, if necessary, provide a diagram of the employee's work area in relation to areas of hazardous noise levels):

8. Off-Duty Exposure (provide any information you may have regarding employee's off-duty exposure to noise, such as hobbies like hunting, dirt biking, etc.):

9. List others who worked in the same area and may have been similarly affected:

_____ _____

Signature Date

Figure 25. Sample of Noise Exposure Work History

SUMMARY OF WORK HISTORY AND OCCUPATIONAL NOISE EXPOSURE

JOB TITLE 1.	EMPLOYER 2.	DATES OF CLAIMED EXPOSURE (YYMMDD) 3. a. FROM	b. TO	SOURCE OF NOISE 4.	SOUND LEVEL RANGE (DBA) 5.	NOISE DISTRIBUTION DURING WORK DAY HOURS 6.	REMARKS 7.
Aircraft Propeller Mech, Hill AFB	USAF	10-14-65	1-6-73	Aircraft Flight Line	89-105 Intermitt.	4 hrs/day	Ear protection was provided & Req. use
Aircraft Elect Hil AFB	USAF	1-7-73	2-28-79	Engine Shop Background	78-86	1 hr/day	Ear protection was provided

Designed using Perform Pro, WHS/DIOR

Figure 26. Skin Disease Checklist

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

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

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

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

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

Form CA-35E
Rev. Aug. 1988

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist

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

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

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

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

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

Form CA-35C
Oct. 1987

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist, Continued

PART A TO BE COMPLETED BY CLAIMANT

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

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

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

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

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

Heavy - Visible airborne asbestos particles were evident.

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

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

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

b. Toxic Chemicals/Dust

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

(PLEASE CONTINUE ON REVERSE SIDE)

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist, Continued

Notice to Employees Filing Claim for Occupational Disease

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

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

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

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

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

Notice to Compensation Specialists and Supervisors

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist, Continued

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

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

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

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

PART B TO BE COMPLETED BY EMPLOYING AGENCY

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

a. Nature of Exposure:

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

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

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

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

b. Degree of Exposure:

Heavy - Asbestos dust was usually visible in the air.

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

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

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

c. Frequency of Exposure: Hours per day.

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

*U.S. Government Printing Office: 1989-229-460/99190

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist, Continued

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

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

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

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

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

Form CA-35F
Rev. Aug. 1988

Figure 27. Asbestos-Related and Work-Related Pulmonary Illness Checklist, Continued

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 28. Form CA-35D, "Evidence Required in Support of a Claim for Work-Related Coronary/Vascular Condition" Checklist

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

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

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

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

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

Form CA-35D
Rev. Aug. 1988

Figure 28. Form CA-35D, "Evidence Required in Support of a Claim for Work-Related Coronary/Vascular Condition" Checklist, Continued

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

We appreciate your cooperation in this effort.

Figure 29. Form CA-35G, "Evidence Required in Support of a Claim for Work-Related Psychiatric Illness" Checklist

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

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

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

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

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

Form CA-35G
Rev. Aug. 1988

Figure 29. Form CA-35G, "Evidence Required in Support of a Claim for Work-Related Psychiatric Illness" Checklist, Continued

MEDICAL REPORT FOR PSYCHIATRIC CLAIM

You should submit a medical report from your physician which includes:

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

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 30. Form CA-35H, "Evidence Required in Support of a Claim for Work-Related Carpal Tunnel Syndrome" Checklist

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

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

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

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

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

a. Dates of examinations;

b. Complete medical history of condition;

c. Medical diagnosis of condition;

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

e. Treatment to date and prognosis;

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

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

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

Form CA-35H
October 1987

Figure 30. Form CA-35H, "Evidence Required in Support of a Claim for Work-Related Carpal Tunnel Syndrome" Checklist, Continued

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 31. Form CA-35A, "Evidence Required in Support of a Claim for Occupational Disease" Checklist

Evidence Required in Support of a Claim for Occupational Disease

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

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

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

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

Form CA-35A
Rev. Aug.1988

Figure 31. Form CA-35A, "Evidence Required in Support of a Claim for Occupational Disease" Checklist, Continued

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

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

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

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

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

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

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

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

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

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

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

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

We appreciate your cooperation in this effort.

Figure 32. Sample Letter to OWCP Regarding Claimant No Longer Employed

D

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of FECA Claim - Orville G. Flye, DOI-Unknown

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

Reference is made to the attached Form CA-2 submitted by Mr. Orville G. Flye, in which he is claiming compensation for his asbestosis condition. He alleges that his condition resulted from exposure to asbestos while he was employed as a Steamfitter at Brookley Field in 1946 and 1947.

As you are aware, Brookley Air Force Base was closed in the late 1960s. Because of this we have no personal knowledge what his duties, working conditions or who his supervisors were at that time. We have not completed the reverse side of Form CA-2.

We have, however, obtained his official personnel folder and medical records from the National Records Center. Based on our review of the documents contained therein, the following information concerns his Federal employment:

a. He was initially employed at Brookley Field from 8 April 1942 through 15 July 1944 when he was placed on military furlough. During this period, he worked as a General Mechanic Helper, Junior Machinist, and Machinist with no exposure indicated.

b. On 9 July 1946, he was reemployed following his military service and was terminated (displacement) on 15 May 1947. During this period, he did work as a Steamfitter, Grade 14, Step 4. His starting and ending salaries were $1.28 per hour and $1.40 per hour, respectively. According to an SF 57, "Application for Federal Employment," submitted and signed by Mr. Flye, his duties consisted of "repairs on

steam traps, valves, hot water lines, steam and return lines, rework steam regulator valves, traps, condensation pumps, reinsulated boilers, and steam lines." His supervisor at that time was Capt Bill Smith.

c. On 18 September 1947, he was again reemployed at Brookley where he worked until he retired. On his application for disability retirement, he described his disabilities as arthritis all over his body, heart disease, and hypertension. Although his last day of work was 29 May 1967, his disability retirement was not effective until 17 August 1967. On his last day of work, he was an Electrical Components Quality Control Inspector, W(WB)2870, Grade 11, Step 3, $3.21 per hour. It is noted that while he was apparently in a sick leave status he was promoted with a change in appointing authority to Kelly Air Force Base, Texas. No exposure is indicated during this 20-year time frame. From his documented work history, it appears that during periods of non-Federal employment (both prior to and after the 1946-1947 period), he may have incurred considerable asbestos exposure when he worked around shipyards, shingles and insulation materials. For example, asbestos exposure while working at shipyards would normally be expected to be much greater than that of an Air Force installation where exposure would probably be only 10 to 15 minutes a day. Possible periods of considerable non-Federal exposure are:

(1) From 1938 - 1939, when he was employed by the South Mississippi Steamship Co., Jacksonville, Florida, as a Laborer painting and cleaning ships.

(2) From October 1939 to August 1940, when employed at the Atlas Roofing Co., Birmingham, Alabama, as a Shingle Stacker stacking shingles on pallets to be placed in dryer kims.

(3) From September 1940 to April 1942 and from June 1947 to September 1947, when employed at the Georgia Dry Dock and Ship Co. as a Pipefitter, where he did new and repair work on all kinds of steam ships. (The latter period immediately followed the alleged Air Force exposure.)

(4) From 1956 to 1958, when he worked part-time (10 hours a week) as a commercial electrician wiring houses, installing electric hot water heaters, water pumps, and electrical components. (This is also after the 1946-1947 period and it appears that this type of work could easily result in asbestos exposure from insulation materials.)

The evidence presented in the medical record does not document any parenchymal

pulmonary fibrosis as a result of asbestos exposure. There is no evidence of any pulmonary or general medical disability as a result of his past asbestos exposure. Calcified pleural placques as a result of asbestos exposure are considered "benign." They cause no pulmonary disability and are not a precursor to future pulmonary disease. Since pleural calcifications can be caused by conditions other than asbestosis and Dr. Jones' report (1) does not provide reasoned medical opinion to support causal relationship, or (2) a diagnosis of asbestosis (as claimed by Mr. Flye), we request that Mr. Flye's X-rays be sent to us for review and interpretation by one of our radiologists with expertise in asbestos-related pulmonary disease.

The X-rays can be sent to the undersigned or to John Williams, M.D., Chief of Occupational Medicine Services, HQ AFMCISGPO, Wright-Patterson AFB, Ohio, 45433-5001.

Prior to adjudicating Mr. Flye's claim, it is recommended that he be required to complete Forms CA 935 and 936 so that Social Security records can be obtained to ascertain any other periods and places of employment following the alleged Federal exposure. Furthermore, should the claim be approved, we believe he should be entitled to medical benefits only as the claimed condition will not add to his already totally disabled status. Copies of pertinent documentation contained in his OPF are enclosed in the indexed evidence packet. It is interesting to note that if there were other records in the OPF which would have been helpful, they were sent to Mr. Flye on 13 November 1993. The chargeback code for this claim would be 3721 UL (MOAMA Old).

We would appreciate your keeping us advised of the status and the final decision. If further assistance is needed, please contact me at 614-522-0001 or Dr. Williams at (614) 522-0002.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

2 Encl
1. Form CA-2
2. Evidence File

Figure 33. Sample Worksheet for Computing COP for Intermittent, WAE, or Part-Time Employees

EMPLOYEE: _____ CLAIM NO: _____

DOI: _____

1. A. Weekly pay rate:
$ _____
Total pay earned (excluding overtime) during 1 year before the injury divided by the total number of weeks worked (excluding overtime).

B. Compute 150 day rule:
$ _____
Total pay earned during 1 year before the injury divided by total hours worked (excluding overtime) = hourly pay rate. Average hourly pay rate times 8 times 150 divided by 52 equals average weekly earnings.

2. Salary for a full week of COP: $ _____
Use the highest rate in 1.A or 1.B.

3. For partial weeks of COP:
$ _____
Subtract actual earnings during the week of COP from the established pay rate.

EXAMPLE

1.(A) Earnings for 1 year prior = $24,343.20.
49 weeks worked: $24,343.20 divided by 49 $496.80 weekly pay rate.
or 150 Day Rule

Figure 33. Sample Worksheet for Computing COP for Intermittent, WAE, or Part-Time Employees, Continued

1.(B) Earnings for 1 year prior = $24,343.20.
49 weeks worked times 40 hours = 1960 hours worked
$24,343.20 divided by 1960 hours times 8 times 150 divided by 52 equals average weekly earnings of $286.61.

1.(A) is greater than 1.(B).

Employee earns $12.42 per hour. $12.42 X 8 hours = $99.36 per day.
Employee worked 1 day during the COP week: $496.80 - $99.36 = $397.44 COP.

The actual earnings of $99.36 is deducted from the weekly pay rate and COP of $397.44 is paid for the remainder of the COP week.

Figure 34. Sample Letter to OWCP-Occupational Disease vs. Traumatic Injury

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of COP, James O. Smith, DOI: May 27, 1994

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

The attached claim for continuation of pay (COP) benefits from our employee, Mr. James O. Smith, is controverted in accordance with 20 CFR 10.201(a)2, since the stated disability appears to be the result of an occupational illness rather than a traumatic injury.

In Item 13, Cause of Injury, of the CA-1, Mr. Smith states he was subjected to repeated incidents during the workweek of May 23-27, 1994. Since the cause of injury fails to meet the "single workday or shift" requirement of the FECA for a traumatic injury, his claim for COP has been denied pending adjudication of his claim by your office. We request your office confirm our decision by upholding the controversion.

Figure 34. Sample Letter to OWCP-Occupational Disease vs. Traumatic Injury, Continued

Your earliest consideration of our request is appreciated. If you have any questions, please contact Jane I. Green at (614) 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-1
2. Form CA-20
3. OWCP-1500

cc: Mr. James O. Smith
Supervisor

Figure 35. Sample Controversion Letter-Traumatic Injury Not Reported Within 30-Day Time Period

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of COP, James O. Smith, DOI-27 May 1994

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

The attached claim for continuation of pay (COP) benefits from our employee, Mr. James O. Smith, is controverted in accordance with 20 CFR because he did not report his injury within the 30-day time limitation.

In Item 10 of the Form CA-1, Mr. Smith states the injury occurred on 27 May 1994. In Item 11, however, he states the date of notice as 30 June 1994. The supervisor was not aware of any injury until the notice was filed on the 30 June date. In view of the above facts, his claim for continuation of pay (COP) has been denied pending the adjudication of his claim by your office. We request your office confirm our decision by upholding the controversion.

Figure 35. Sample Controversion Letter-Traumatic Injury Not Reported Within 30-Day Time Period, Continued

Your early consideration of our request will be appreciated. If you have any questions, please contact Jane I. Green at (614) 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-1
2. Form CA-20
3. OWCP-1500

cc:
James O. Smith
Supervisor

Figure 36. Sample Controversion Letter-Work Stoppage Occurred After 45-Day Time Period

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of COP, James O. Smith, DOI-25 April 1999

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

The attached claim for continuation-of-pay (COP) benefits from our employee, Mr. James O. Smith, is controverted in accordance with 20 CFR 10.201(a)4 because his work stoppage did not occur within the 45-day time limitation.

Mr. Smith did timely report the injury on Form CA-1; however, he did not obtain medical treatment nor did he lose time from work due to the reported injury until 25 July 1999. Consequently, his claim for COP has been denied pending the adjudication of his claim by your office. We request your office confirm our decision by upholding the controversion.

Figure 36. Sample Controversion Letter-Work Stoppage Occurred After 45-Day Time Period, Continued

Your early consideration of our request will be appreciated. If you have any questions, please contact Jane I. Green at (614) 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-1
2. Form CA-20
3. OWCP-1500

cc:
James O. Smith
Supervisor

Figure 37. Sample Controversion Letter-Injury Reported After Employee Was Terminated

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of COP, James O. Smith, DOI-16 May 1994

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

The attached claim for continuation of pay (COP) benefits from our former employee, Mr. James O. Smith, is controverted in accordance with 20 CFR 10.201, 4c because he did not report (either verbally or written) his alleged injury until after he had been terminated from our employment rolls.

Please note that the Form CA-1, Item 11 shows the date of notice as of 25 May 1994. The termination of Mr. Smith's appointment was 20 May 1994. Accordingly, we have advised Mr. Smith that he is not eligible for continuation of pay. A copy of the SF 50 showing termination of his appointment is attached for your information and records. We request your office confirm our decision by upholding the controversion.

Figure 37. Sample Controversion Letter-Injury Reported After Employee Was Terminated, Continued

Your early consideration of our request will be appreciated. If you have any questions, please contact Jane I. Green at (614) 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

4 Encl
1. Form CA-1
2. Form CA-20
3. OWCP-1500
4. SF 50

cc:
James O. Smith
Supervisor

Figure 38. Sample Controversion Letter-Diagnosis Not Compatible With Injury

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of FECA Claim - James G. Blue, DOI-3 January 1994

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

We request that status of James G. Blue's claim be changed from noncontroverted to controverted for the reasons stated below. According to Mr. Blue's Form CA-1, he sustained a minor contusion to his left ankle while in the performance of duty on 3 January 1994. He accepted treatment at our medical facility, was found fit for duty and returned to work. He worked without incident through 7 January 1994. On 10 January 1994, Mr. Blue contacted this office stating his ankle was still bothering him, requested he be granted COP and authorization to see his private physician, Dr. Thomas. Mr. Blue's supervisor issued a Form CA-16 authorizing medical treatment for the ankle injury and mailed it to Dr. Thomas the same day. Mr. Blue was subsequently hospitalized for surgery, and as of this date has not returned to duty.

We have carefully reviewed the attached Form CA-16, recent correspondence from Dr. Thomas, and the hospital reports. Although Dr. Thomas's letter of 11 January 1994 led us to believe that the claimant was being hospitalized for his ankle injury, these attachments indicate otherwise. This evidence shows that Mr. Blue was hospitalized and treated for a health problem unrelated to his ankle injury or to his Federal employment. Further, it does not provide reasoned medical opinion of relationship between Mr. Blue's ankle injury to the hospitalization and surgery for "gangrenous appendix."

We believe that Mr. Blue is attempting to abuse the provisions of the FECA and is being aided by his treating physician. Since the attached documentation clearly shows

Figure 38. Sample Controversion Letter-Diagnosis Not Compatible With Injury, Continued

that Mr. Blue's disability is not related to his claimed injury, we request his claim be denied in its entirety.

Thank you for your consideration of our request. If you have any questions, please call me at (614) 522-5001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-16
2. Dr. Thomas's letter
3. Hospital Records

cc: James G. Blue

Figure 39. Sample Controversion Letter-Injury Not In Performance of Duty

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of FECA Claim - Mary A. Brown, DOI - 3 January 1994

TO: Office of Worders' Compensation Programs
Street Address
City, State Zip Code

Dear Claims Examiner:

The information contained in the attached Form CA-1 submitted by Ms. Mary A. Brown, the supervisor and activity medical officer's statements, and the Form CA-20 indicate that Ms. Brown's medical condition is not related to employment factors. Instead, the attachments show that Ms. Brown did not incur her injury in the "performance of duty."

According to the documentation, the claimed injury did occur on the employer's premises. However, the time of the incident was 40 minutes prior to the beginning of Ms. Brown's work shift, and the act of showering in our Government facility was not required in the performance of her duties but for her own personal satisfaction and convenience. Due to a power failure at her home, she was without hot water and decided to shower at work. Ms. Brown had not established a pattern or routine of a morning shower at work, and we consider her indulgence a substantial deviation from her employment.

As stated above, the injury occurred on the premises but did not arise out of her employment as this act did not have any relationship to the work she was employed to perform nor was it incidental to her contract of employment. We believe her injury is not covered by the FECA and that the claim should be denied. We have advised Ms. Brown that we are controverting her claim.

Figure 39. Sample Controversion Letter-Injury Not In Performance of Duty, Continued

Your early decision on this claim will be appreciated. If you have any questions, please contact Jane I. Green at (614) 522-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

3 Encl
1. Form CA-1
2. Supervisor's Statemet
3. Doctor's Statement

cc: BBBB-BB (Mary A. Brown)

Figure 40. Sample Controversion Letter-Occupational Disease Not Related to Employment

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Controversion of FECA Claim - James G. Blue, DOI: January 3, 1994

TO: Office of Workers' Compensation Program
Street Address
City, State Zip Code

Dear Claims Examiner:

We are forwarding the enclosed Form CA-2, "Notice of Occupational Disease and Claim for Compensation," filed by our employee, James G. Blue, for your adjudication. We cannot concur that Mr. Blue's claim for severe sinus condition is caused by his employment with the U.S. Air Force. Mr. Blue alleges that he works in a dusty, closed-in environment, which causes him to have difficulty in breathing, headaches, and sinus congestion.

Recently taken dust samplings (Encl 2) are well within OSHA standards in the area where he works. The base supply store where he stocks shelves is vacuumed and dusted daily (Encl 3) and the building is equipped with an air conditioning system, which filters the air as well as provides a comfortable temperature (Encl 4). Please note that Mr. Blue suffered a sinus condition prior to being employed by the U.S. Air Force (Encl 5).

Mr. Blue's personal statement and the comments submitted by his immediate supervisor are enclosed as required. Please note the discrepancy between Mr. Blue's statements and those of his supervisor concerning the nature and the duration of the claimant's exposure to substances.

Figure 40. Sample Controversion Letter-Occupational Disease Not Related to Employment, Continued

Based on all available information concerning Mr. Blue's claim, we do not believe that his sinus condition is casually related to his employment factors. We request your thorough review of this claim based on the evidence submitted in this letter.

If you have any questions, please call me at (614) 552-0001.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

5 Encl
1. Form CA-2 w/Supv & Empl Stmt
2. Samplings
3. Statement
4. Temperature Reading
5. Physical

CC: BBBB-BB (Mr. James G. Blue)

Figure 41. Sample Firefighters Computation Worksheet

WORKSHEET FOR COMPUTING FIREFIGHTERS PAY

Pay Rate is absed on 144 hours per 14-day work period. Total hours are 144 (106 regular hours plus 38 hours overtime).

EMPLOYEE: _____ CLAIM NO: _____

1. Grade and step on date of injury, date disability began or date of recurrence GS5/5

2. Use the greater of per annum basic pay rate on date of injury, DOR or DDB: (Obtain from SF 50 and attach a copy of SF 50) $23,686

3. Premium Pay Percentage: 25 Percent X or 22 Percent _____
(25 percent applies if firefighter works on a Sunday;
22 percent applies if firefighter works no Sundays.)

FORMULA

4. Item 2 divided by 26 = Basic Pay $911

5. Item 4 X .25 (or .22) = Standby Premium Pay $227.75

6. Item 4 + Item 5 = Total Remuneration $1138.75

7. Item 6 divided by 144 = Hourly regular rate $7.91

8. Item 7 X .50 X 38 = FLSA Overtime $150.29

9. Item 6 + item 8 = Total Biweekly Pay $1289.04

10. Item 9 divided by 2 = Weekly Pay Rate $644.52

11. To obtain hourly rate divide item 10 by 72: $8.95

Figure 41. Sample Firefighters Computation Worksheet, Continued

WORKSHEET FOR COMPUTING FIREFIGHTERS PAY (Blank)

Pay Rate is absed on 144 hours per 14-day work period. Total hours are 144 (106 regular hours plus 38 hours overtime).

EMPLOYEE: _____ CLAIM NO: _____

1. Grade and step on date of injury, date disability began. or date of recurrence _____

2. Use the greater of per annum basic pay rate on date of injury, DOR or DDB:
(Obtain from SF 50 and attach a copy of SF 50) _____

3. Premium Pay Percentage: 25 Percent _____ or 22 Percent _____
(25 percent applies if firefighter works on a Sunday;
22 percent applies if firefighter works no Sundays.)

FORMULA

4. Item 2 divided by 26 = Basic Pay

5. Item 4 X .25 (or .22) = Standby Premium Pay _____

6. Item 4 + Item 5 = Total Remuneration_____

7. Item 6 divided by 144 = Hourly regular rate_____

8. Item 7 X .50 X 38 = FLSA Overtime_____

9. Item 6 + item 8 = Total Biweekly Pay_____

10. Item 9 divided by 2 = Weekly Pay Rate_____

11. To obtain hourly rate divide item 10 by 72: _____

Figure 42. Consumer Price Index

COST OF LIVING ADJUSTMENTS UNDER 5 U.S.C. 8146a

EFFECTIVE DATE	RATE	PERIOD SINCE LAST CPI		EFFECTIVE DATE	RATE	PERIOD SINCE LAST CPI	
		DAYS*	MONTHS			DAYS*	MONTHS
10/1/66	12.5%	--	--	4/1/80	7.2%	183	6
1/1/68	3.7%	457	15	9/1/80	4.0%	153	5
12/1/68	4.0%	335	11	3/1/81	3.6%	181	6
9/1/69	4.4%	274	9	3/1/82	8.7%	365	12
6/1/70	4.4%	273	9	3/1/83	3.9%	365	12
3/1/71	4.0%	273	9	3/1/84	3.3%	366	12
5/1/72	3.9%	427	14	3/1/85	3.5%	365	12
6/1/73	4.8%	396	13	3/1/87	.7%	730	24
1/1/74	5.2%	214	7	3/1/88	4.5%	366	12
7/1/74	5.3%	181	6	3/1/89	4.4%	365	12
11/1/74	6.3%	123	4	3/1/90	4.5%	365	12
6/1/75	4.1%	212	7	3/1/91	6.1%	365	12
1/1/76	4.4%	214	7	3/1/92	2.8%	366	12
11/1/76	4.2.%	305	10	3/1/93	2.9%	365	12
7/1/77	4.9%	242	8	3/1/94	2.5%	365	12
5/1/78	5.3%	304	10				
11/1/78	4.9%	184	6				
5/1/79	5.5%	181	6				
10/1/79	5.6%	153	5				

* Calendar Days

Prior to 9/7/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.23 on a weekly basis ($.23, $.46, $.69. or $.92). After the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.25 on weekly basis ($.25, $.50, $.75, or $1.00).

Prior to 11/1/74 .08 - .34 = .23
.35 - .57 = .46
.58 - .80 = .69
.81 - .07 = .92

Effective 11/1/74 .13 - .37 = .25
.38 - .62 = .50
.63 - .87 = .75
.88 - .12 = 1.00

Figure 43. Shadrick Formula

SHADRICK FORMULA

1. Pay Rate when: $ _____
   a. Injured
   b. Disability began
   c. Compensable Disability Recurred

2. Current pay rate for job and step when injured: $ _____
   (This is a very important step in the formula.
   In many cases, overpayments occur because the
   recurrence or date disability began pay is used.
   It is important to know the grade and step on
   the date of injury to submit the current pay rate.)

3. a. Is capable of earning $ _____
   b. Has actual earnings of $ _____

4. WEC (Item 3 divided by Item 2) _____%

5. WEC (Item 4 times Item 1) $ _____

6. Loss of WEC (Item 1 minus Item 5) $_____

7. Compensation (Item 6 times ( ) 2/3 or ( ) 3/4 $_____

Figure 44. Form CA-7A, "Time Analysis Form"

Time Analysis Form

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
JOHNSON, Rosemary A.	555-44-9999	11-88888

4. Period Covered by This Form: From: 03 / 05 / 96 To: 03 / 18 / 96

5. Total Hours Claimed for LWOP: for Leave Buyback: 60

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		
03-05-96 -- 03-12-96	Yes				48	S	Total Disability
03-13-96	Yes				8	A	Total Disability
03-18-96	Yes				4	S	Doctor's Appointment
Totals							

Rosemary A. Johnson — Signature of Claimant — 3-20-96 — Date Signed

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

NOTE: Employee completes items 1 - 6; supervisor certifies)

Thomas J. Smith — Signature of Agency Official — 3/21/96 — Date Signed

Figure 45. Instructions for Completing Form CA-7A

Instructions for Completing Form CA-7A
Time Analysis

General: This form is used when claiming FECA compensation, including repurchase of paid leave. It must be used when claiming compensation for more than one consecutive period of leave.

Instructions for Employee:

Blocks 1, 2, and 3: Self-explanatory.

Block 4: Indicate beginning and ending dates covered by this form. These must be the same as on Forms CA-7 and CA-7b.

Block 5: If claiming compensation for any dates detailed in block 5, state total number of hours claimed for leave without pay and total number of hours of leave. This should be at least 10 hours unless this is your final claim.

Block 6:

1st Column:	Show full date.
2nd Column:	For each date noted in column 1, state "Y" if you are claiming compensation for that date and "N" if you are not.
3rd, 4th, 5th and 6th Columns:	Show the number of hours of LWOP, number of hours worked, paid holiday hours, and number of hours of paid leave.
7th Column:	Using the legend provided, indicate the type of leave used.
8th Column:	State the reason you were off work. For each date for which compensation is claimed, there must be medical evidence supporting entitlement.

Sign and Date Form and Submit to the Appropriate Agency Official.

Instructions for Employing Agency:

Block 7: Verify accuracy of hours and status for each date listed. If challenging entitlement for any date, attempt to resolve discrepancies prior to submitting claim to OWCP. If discrepancy cannot be resolved, indicate the specific basis for the challenge in the space provided.

5

Figure 46. Leave Buy Back Worksheet/Certification and Election Form

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. $ _____

Page 1

Form CA 7b
June 1996

Figure 46. Leave Buy Back Worksheet/Certification and Election Form, Continued

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

Figure 46. Leave Buy Back Worksheet/Certification and Election Form, Continued

Instructions . . Form CA-7B
Leave Buy Back Worksheet

This form is intended to accompany Form CA-7, *Claim for Compensation*, when the employee is claiming leave buy back.

Things to Know About Leave Buy Back:

When an employee uses their sick or annual leave to cover an injury-related absence from work, they may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 3/4 with 1 or more dependents. The agency pays leave at 100% of salary. In order for leave to be reinstated, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency.

The employee's pay status must be changed to LWOP in order for compensation to be paid. Leave is not earned while in LWOP. Also, contributions to the Thrift Savings Plan (TSP) are not made during LWOP. Therefore, the repurchase of leave may result in a reduction in an employee's leave and/or TSP balance. Consult your personnel office to learn how the change to LWOP would effect you.

When a Leave Buy Back (LBB) payment is made during the same year that leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. Where leave repurchase is not completed during the same year in which leave is used, the employee may not adjust their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Further questions regarding tax implications of LBB should be addressed to the IRS.

A claimant may not repurchase leave used during a period they were eligible for COP.

When disability does not exceed 14 days beyond the COP period, 3 day LWOP must be charged before compensation can be paid. If leave was used for this period, compensation can not be paid for the 3 days, but the claimant will have to pay back leave paid during the 3 days to repurchase the leave.

Instructions to the Employee:

Please submit a claim for a minimum of 10 hours unless no further claim is anticipated. Medical documentation must be provided for all dates claimed.

1. Complete the Form CA-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete Form CA-7a following the instructions for completing that form.

2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.

3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, and the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.

   a. If the total amount of FECA benefits estimated by the agency is not more than 10% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.

   b. If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Office will offer you a new election with the correct amount of FECA benefits payable.

Page 3

Figure 46. Leave Buy Back Worksheet/Certification and Election Form, Continued

Instructions to the Agency:

Items A through D *(top of form)* are self-explanatory.

Section I. Agency Estimate of FECA Entitlement:

Item A: Enter all three pay rate types and effective dates if applicable. Choose the greatest amount of the three and enter the amount and effective date in Line 1. A recurrent pay rate should only be used if: (1) the employee stops work more than 6 months following their first return to regular, full time duty and (2) the loss of time is due to disability rather than medical examinations or treatment.

For unusual situations, please refer to Payrate Desk Aid.

Item B: If the employee works a regular schedule, enter the differentials earned weekly. If an irregular schedule, give the total amount earned for the year prior to the date in Line 1 divided by the number of weeks worked in that year.

Please refer to Payrate Desk Aid for guidance on inclusions and exclusions. If in doubt, consult a Claims Examiner.

Item C: Add lines 1 through 5 and enter the total in Line 6.

Item D: Circle the appropriate rate: 2/3 for employees without dependents; 3/4 with dependents. Dependents include: spouse; children under 18 living with or supported by the employee; children under 23 in school full time; children over 18 incapable of self support; and parents wholly supported by the employee.

Item E: Enter the total hours ***claimed***, from Form CA-7a.

Item F: Enter the total hours in the employee's normal work week.

Item G: Formula for FECA Entitlement. Use this formula to calculate estimate of FECA entitlement and enter the result in Line 10.

Example of computation: The weekly pay from line 6 is $574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:

$574.00 x 3/4 x 82 hours ÷ 40 hours = $882.52

Section II. Agency Certification:

Item H & I are self-explanatory. For Line J, subtract Line I from Line H.

Sign and date, and advise the employee of the amount they owe to the agency.

Section III. Employee Claim:

If the employee elects not to repurchase the leave, retain the form in the agency files. If the employee elects to repurchase the leave, submit all claim documents (CA-7, CA-7a & CA-7b) plus any medical documentation to OWCP for processing.

Page 4

Figure 47. Leave Buy Back Flow Chart

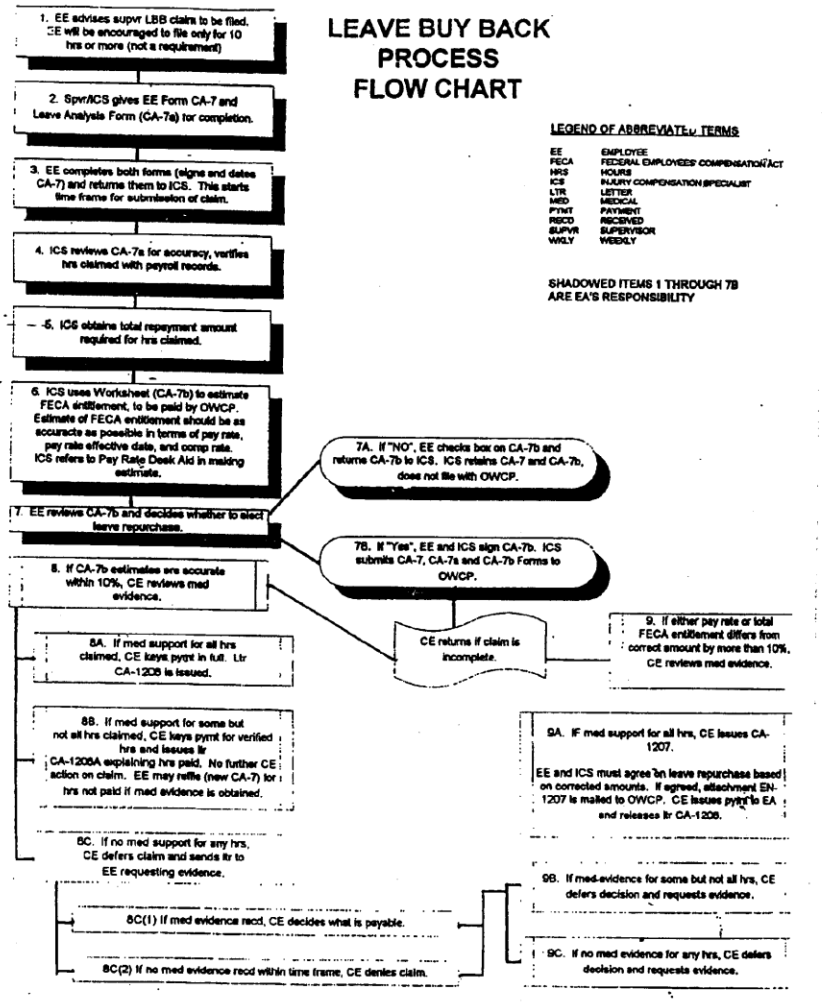


Figure 48. Instructions for Using Tables to Compute Program Costs/Savings

INSTRUCTIONS FOR USE OF TABLES
FOR DETERMINING FECA PROGRAM COSTS/SAVINGS

Using table A, take claimant's year of birth, follow horizontally to current calendar year to determine number of years to age 70. Multiply the number of years to age 70 times the current annual compensation cost.

EXAMPLE: Claimant was born in 1945 and receives $20,000 per annum. From 1945 to column for the current year when computing projected cost (in this instance 1994 is used) = 21 years to age 70. Multiply $20,000 by 21 = $420,000.

Using Table B, find corresponding inflation factor to number of years determined using Table A. Multiply factor times the cost determined in A.

EXAMPLE: $420,000 X 1.696 (22 years used in A) = $712,320.

NOTE: A 5 percent constant inflation factor was determined to be as conservatively realistic as any other factor per discussion with several experienced budget analysts.

Figure 49. Tables for Computing Lifetime Cost Avoidance

TABLES FOR DETERMINING FECA PROGRAM LIABILITIES/COST AVOIDANCE BASED ON LIFE EXPECTANCY OF AGE 70

YEAR OF BIRTH	TABLE A CALENDAR YEAR				TABLE B INFLATION	
	1994	1995	1996	1997	YEARS	FACTOR
1919	0	0	0	0	1	1.00
1920	0	0	0	0	2	1.025
1921	0	0	0	0	3	1.05
1922	0	0	0	0	4	1.075
1923	0	0	0	0	5	1.102
1924	0	0	0	0	6	1.1
1925	1	0	0	0	7	1.166
1926	2	1	0	0	8	1.19
1927	3	2	1	0	9	1.221
1928	4	3	2	1	10	1.254
1929	5	4	3	2	11	1.287
1930	6	5	4	3	12	1.322
1931	7	6	5	4	13	1.358
1932	8	7	6	5	14	1.395
1933	9	8	7	6	15	1.434
1934	10	9	8	7	16	1.473
1935	11	10	9	8	17	1.515
1936	12	11	10	9	18	1.558
1937	13	12	11	10	19	1.602
1938	14	13	12	11	20	1.648
1939	15	14	13	12	21	1.696
1940	16	15	14	13	22	1.745
1941	17	16	15	14	23	1.796
1942	18	17	16	15	24	1.849
1943	19	18	17	16	25	1.904
1944	20	19	18	17	26	1.961
1945	21	20	19	18	27	2.02
1946	22	21	20	19	28	2.081
1947	23	22	21	20	29	2.144
1948	24	23	22	21	30	2.21
1949	25	24	23	22	31	2.278
1950	26	25	24	23	32	2.348
1951	27	26	25	24	33	2.421
1952	28	27	26	25	34	2.497
1953	29	28	27	26	35	2.576

Figure 49. Tables for Computing Lifetime Cost Avoidance, Continued

TABLES FOR DETERMINING FECA PROGRAM LIABILITIES/COST AVOIDANCE BASED ON LIFE EXPECTANCY OF AGE 70--Continued

YEAR OF BIRTH	TABLE A CALENDAR YEAR				TABLE B INFLATION	
	1994	1995	1996	1997	YEARS	FACTOR
1954	30	29	28	27	36	2.657
1955	31	30	29	28	37	2.742
1956	32	31	30	29	38	2.83
1957	33	32	31	30	39	2.921
1958	34	33	32	31	40	3.015
1959	35	4	33	32	41	3.113
1960	36	35	34	33	42	3.215
1961	37	36	35	34	43	3.32
1962	38	37	36	35	44	3.43
1963	39	38	37	36	45	3.544
1964	40	39	38	37	46	3.662
1965	41	40	39	38	47	3.785
1966	42	41	40	39	48	3.912
1967	43	42	41	40	49	4.044
1968	44	43	42	41	50	4.182
1969	45	44	43	42		
1970	46	45	44	43		

Figure 50. Sample Letter to Physician Explaining Difference Between Disability Retirement and Workers' Compensation

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Federal Employees Injured at Work

TO: Amos B. Jackson, M.D.
Street Address
City, State Zip Code

Dear Dr. Jackson:

Reference is made to your recent medical report for our employee, James A. Smith, concerning his/her application for disability retirement. Mr. Smith also has a documented work-related injury and (may be/is) covered under the Federal Employees' Compensation Act.

On occasion, when a private physician recommends medical or disability retirement, it may not necessarily mean that the employee is totally disabled for all work. We are aware that a great deal of misunderstanding exists (in both the Federal and non-Federal sectors) concerning entitlement to benefits under the Federal Disability Retirement and the Workers' Compensation Programs. To clarify this misunderstanding, the following explanation is offered:

Workers' Compensation Program: If an employee is injured on the job and is unable to perform any duties because of physical limitations resulting from the injury, he/she is entitled to Office of Workers' Compensation Programs (OWCP) payments, which are nontaxable and can be up to three-fourths of his/her current salary. The Congress did intend for an employee to receive full compensation payments for all periods of total disability, but only if the employee is disabled for all gainful employment. It, however, did not intend this to be a permanent retirement program because injured workers are usually able to return to some type of productive light or sedentary work. To be entitled to continuing Workers' Compensation, the employee's disability must always be monitored until maximum medical improvement is reached and periodic

Figure 50. Sample Letter to Physician Explaining Difference Between Disability Retirement and Workers' Compensation, Continued

medical reviews are scheduled to guard against any error. To maintain motivation and work skills, the employee should return to the work place or be placed in a rehabilitation program as soon as possible. When the injured employee is unable to return to his/her former job, the employer can normally make use of the employee's acquired skills or place him/her in a job where he or she can develop new skills. For example, it may be possible to reengineer the employee's current position or offer a different one with physical qualifications compatible to the work limitations imposed by the treating physician. If the employer cannot do this, the Office of Workers' Compensation Programs may then place the employee in a rehabilitation or retraining program so that he/she can learn to function in a work situation that is compatible to his/her physical limitations. In either event, the employee is entitled to continuing compensation based on his/her ability to earn wages.

Disability Retirement Benefits: An employee may be eligible for disability retirement benefits when he/she has been covered by the CSRS or FERS retirement system for the specified period of that particular retirement system, (5 years or 18 months) and is unable to perform the full duties of his/her current position. The retirement annuity is based on years of service, is normally less than OWCP benefits, and is taxable. The employee's disability does not have to be work-related.

We would not disagree with a recommendation for disability retirement nor the employee receiving retirement benefits if he/she cannot continue in his/her current position. The compensation law, however, is not designed to entitle an employee to full workers' compensation benefits when he/she can perform some type of work. For this reason, we would appreciate your completing the attached Form CA-17 concerning Mr. Smith's current work limitations/restrictions. If he can perform any type of work, we will take action to place him on a position in strict accordance with your stated physical restrictions.

Figure 50. Sample Letter to Physician Explaining Difference Between Disability Retirement and Workers' Compensation, Continued

We appreciate your cooperation in this matter and look forward to working with you. If you have any questions, please contact the injury compensation specialist, at 522-0001 or our Medical Officer, _____ at 522-0002.

Sincerely,

MELVIN A. BROWN
Injury Compensation Program
Administrator

Encl
Form CA-17 w/Envelope

Figure 51. Sample Letter to Former Employee of Job Offer with Copy of Acceptance/Declination of Job Offer

USE INSTALLATION LETTERHEAD

FROM: AAAA-CC Date

SUBJECT: Job Offer

TO: Mrs. Jane B. Reed
Street Address
City, State Zip Code

Dear Mrs. Reed:

The current medical information in your compensation file indicates that you can perform certain work assignments. We are offering you the following position:

Job Title:	Engine Records Clerk
Pay Plan/Series/Grade:	GS-303-04-01
Salary:	$16,900 per annum
Work Schedule:	Monday through Friday, 0800 - 1630
Organization/Location:	Directorate of Maintenance Pearl Harbor Naval Shipyard Pearl Harbor, HI 96860-5352
Date Job Available:	2 February 1994

The job will remain available until OWCP has made their determination regarding the job offer. This position is the best position that can be offered at this time and is specifically within the limitations given by the reporting physician.

The following describes the duties and environmental requirements of this position. While sitting in a chair, input engine record data into a remote computer terminal. The terminal is at eye level when the operator is in a sitting position, and no reaching or working above shoulder level is required. You may occasionally (twice daily) carry computer listings (weighing no more than 5 pounds) for short distances, approximately 50 feet. You may be required to walk short distances on an intermittent basis, not to

Figure 51. Sample Letter to Former Employee of Job Offer with Copy of Acceptance/Declination of Job Offer, Continued

exceed a total of one hour per day. You will be allowed to sit or stand at your convenience, for comfort, and you will be permitted to take frequent walks. A copy of the official position description is also attached for your information.

If you decline this position, and OWCP determines that this is a job that you can do, your benefits under the Federal Employees' Compensation Act will be terminated (except for medical benefits). If you accept this position, the necessary information for determination of loss of wage earning capacity, if any, will be provided to the OWCP claims examiner. In considering this action, you need to be fully aware of the effect this will have on your disability retirement.

If you accept this offer of employment, we will notify the Office of Personnel Management (OPM), Office of Retirement Programs, of your reemployment status. If OPM finds you recovered, your entitlement to disability retirement may be terminated. Future retirement benefits would then be determined under applicable law at that time. Your decision as to acceptance or declination of this offer should be made in writing within 15 days of your receipt of this letter. The enclosed Acceptance/Declination Statement and our self-addressed envelope are provided for this purpose.

Figure 51. Sample Letter to Former Employee of Job Offer with Copy of Acceptance/Declination of Job Offer, Continued

If you have any questions, contact Melvin A. Brown at (614) 522-0001.

Sincerely,

JACK E. JONES
Chief, Employee Relations Division

4 Encl
1. Accept/Decline Stmt
2. Position Description
3. SF 78
4. Envelope

cc: AAAA-DPCS
OWCP

NOTE TO READER: Remember that the functional requirements of the position must be included in the narrative of the letter. These must comply with the employee's physical limitations. In addition, an SF 78 for the offered position may be provided.

Figure 51. Sample Letter to Former Employee of Job Offer with Copy of Acceptance/Declination of Job Offer, Continued

ACCEPTANCE/DECLINATION STATMENT

PART A

I voluntarily accept the position of _____

_____(Grade), _____(pay-annually/hourly)

I make this acceptance voluntarily without pressure or coercion. I request this action be taken effective:

_____

SIGNATURE _____ DATE _____

****

PART B

I decline this offer of placement to the position of _____

_____(Grade), _____(pay-annually/hourly)

I fully understand the consequence that if I decline the job offer and OWCP determines that this is a job I can perform, that I may be terminated or denied compensation benefits (except for medical benefits) under Section 8106(C) of 5 United States Code

Reason for Declining:

SIGNATURE _____ DATE _____

NOTICE: FAILURE TO RESPOND TO THIS JOB OFFER WILL BE CONSDERED A DECLINATION.

Figure 52. Suspected Fraudulent FECA Claims

SUSPECTED FRAUDULENT FECA CLAIMS/GUIDANCE

The following questions were developed as a checklist for ICPAs, safety specialists, and supervisors to review suspect claims, detect suspicious patterns, and determine the need to take administrative action or refer claims to the appropriate investigative services for criminal investigation.

Information obtained from the questions is intended as a guideline only. Except for questions 14 through 21, a "yes" answer to any one question may not be sufficient to refer a claim to the investigative services, unless there is other information that suggests a problem. More than one "yes" answer may suggest a pattern, and a "yes" answer to questions 14 through 21 should he discussed with investigative personnel. Rationale for the questions is set forth in the discussions below:

SECTION I: ANSWER THE FOLLOWING QUESTIONS FROM INFORMATION OBTAINED.

DATE BEGAN CURRENT EMPLOYMENT: Was injury reported in the first pay period of employment? An injury reported in the first pay period may indicate the claimant did not report a preexisting injury. Examine the Form CA-7, Item 24 for all claimants filing new injury claims. Interview co-workers to find out if the condition existed at the onset of employment.

TOTAL LEAVE BALANCE: Was employee's leave balance very low at time of the injury (for example, five days or less total leave)? Claimants are authorized COP for up to 45 calendar days without loss of leave or break in pay. These payments can act as an incentive for employees to use COP as a substitute for leave. The above factors may indicate that the injury was feigned or its severity exaggerated. Review leave records to identify previous leave problems.

NATURE OF INJURY: Did injury involve soft tissue damage that could be feigned or could have occurred off duty, such as back or muscle strain? Compare claimant and physician descriptions of the injury and examine the Forms CA-1, Item 14, CA-16 and CA-20. Interview supervisors, co-workers, witnesses, and treating physician to develop information indicative of a feigned injury.

Figure 52. Suspected Fraudulent FECA Claims, Continued

DATE INJURY OCCURRED/DATE INJURY REPORTED: Was injury reported on the date it occurred? If not, see discussion in Question 6, below.

SECTION II: THESE QUESTIONS ATTEMPT TO DISCLOSE PROBLEMS IN THE FOLLOWING AREAS.

QUESTION 1: Claims presented by employees who are known to engage in strenuous outside activities may indicate an injury was not job-related. Interview supervisor, co-workers and individuals known to participate with the claimant in outside activities to determine their knowledge of the injury.

QUESTION 2: Employees must establish that injuries were caused or related to their job, or that preexisting injuries or illnesses were accelerated or aggravated because of their employment. If similar medical treatment was received before the job-related injury, the injury (aggravation) may have been feigned or non-job-retated. If a prior non-job-related condition is discovered, make inquiries concerning prior treatment with supervisor and co-workers, and obtain information about the injury from the treating physician. Also, examine Forms CA-1, Items 10 and 13, and CA-16, Items 15 and 16. NOTE: It is also important to identify any preexisting injury or illness in that the new injury may only temporarily aggravate the old. Normally, after a short recuperation period, the aggravation will cease and the old condition returns to its normal state. At this time, the original illness or injury (aggravation) is no longer compensable under the FECA.

QUESTION 3: An unjustified change of physicians may indicate the claimant received a "fitness for work" diagnosis from the attending physician and changed physicians to stay on compensation. Check the name of the current physician with the physician indicated on the Form CA-16. Obtain a statement from the attending physician and consider obtaining further medical examinations or specialized tests if no apparent reason exists for the change.

QUESTIONS 4: Question claimant and review claim files and the Official Personnel Folder for evidence of outside employment. All income from such employment including unremunerated employment must be reported to OWCP. It is possible that the injury may have been caused by secondary employment. Also, claimants may conceal outside income or perform outside work with no pay and continue to receive compensation to which they are not entitled. The SF 171 provides information about the claimant's work experience and past employers. Immediately report suspicions regarding undisclosed earnings or work without pay.

QUESTION 5: Claimants could be overstating their degree of disability and abusing the system. They may be performing volunteer work for various organizations such as churches, boy scouts, girl scouts, and coaching sporting events. Evidence to support this could mean that the claimant is capable of performing some type of suitable work and is not as disabled as me treating physician states. Send such evidence to OWCP and request that the treating physician, or an impartial medical examiner, make a determination of the claimant's medical limitations.

QUESTION 6: Claimants could fraudulently claim a job-related injury immediately following a weekend, holiday, or vacation, for an injury that occurred during an off-duty period. Interview the claimant's supervisor, witnesses, and co-workers to develop information, and review Form CA-1, Items 10, 21, 22, and 32.

QUESTION 7: Review claim files for employees who have transferred or separated and were injured near the end of their employment. Interview supervisors, co-workers, witnesses and, if possible, treating and activity physicians to develop information indicative of a feigned injury or a claim for a preexisting injury or illness. A review of the employee's medical records and OPF may be helpful.

QUESTION 8: Temporary employees are entitled to COP during their appointment and compensation after their termination date. A claim reported at or near the end of the temporary employment period may indicate that the claimant feigned the injury to continue drawing an income. Examine further if a negative answer is indicated in Item 25 of the Form CA-7.

QUESTIONS 9: Claimants may attempt to use COP as a substitute for leave or feign an injury to avoid disciplinary action. Obtain a copy of the SF 71 and statement from the supervisor or person denying the leave request or documentation concerning any proposed disciplinary action taken.

QUESTION 10: Examine Form CA-1, Item 35 to learn the supervisor's reasons for controverting the claim. Although the rationale for controversion may not meet statutory requirements for termination or denial of COP, there may be other factors that have a bearing on the legitimacy of the claim. Once the supervisor provides the rationale for recommending denial, other information may surface.

QUESTION 11: A correlation of dates when COP was taken may indicate that a claimant has seasonal employment or is vacationing during the same period each year.

Review the Form CA-1 and historical records. Obtain copies of payroll leave and attendance records and any disciplinary actions. Interview supervisor, co-workers, and witnesses to obtain information on circumstances surrounding the injury.

QUESTIONS 12: Review claim files to identify employees who act as witnesses for each other. Also, review files to identify employees who have submitted numerous claims. Compare Form CA-1, Items 1, 7, 14, and 16 to learn if the same individuals have acted as witnesses. If patterns are revealed, obtain details of the injuries and how they occurred.

QUESTION 13: Many claimants may use the same physician to establish job-related injury claims. Review claim files to detect if the same physician certified job-related injuries for several employees. Refer suspicions of conspiracy and false medical certification to the appropriate investigative services.

QUESTION 14: Instances have been discovered in which compensation was paid for a new or subsequent non-job related injury or illness for which no new documentation was prepared. Medical bills for the new injury may be included with those for the original injury and paid due to lack of scrutiny. Compare Form CA-20 with Form CA-1. If such information is received, interview the attending physician and determine if the claimant was treated for a subsequent injury. Interview supervisors and co-workers about their knowledge of the second injury and its circumstances. Inform the appropriate investigative services and the servicing OWCP office of the allegations.

QUESTION 15: Claimants may have received compensation for a lengthy period without support of medical evidence of disability. Compare the Agency case file and the DOL chargeback bills to find out if medical bills are being paid. If not, request OWCP to provide reasons why not, and to provide a current medical report and OWCP-5.

QUESTION 16: Claimants may provide false information on documents when initiating a claim, or alter information provided by supervisors and witnesses, or make written false statements to OWCP. Also, a claimant may have access to physician reports and alter medical information concerning the severity of the injury, the manner in which it occurred, and the effect it will have on future job performance. These forms could also be acquired independently and forwarded to OWCP with false information or forged physician's signature. Attach questionable documents to cases referred for investigation.

QUESTION 17: Compare statements of claimant, supervisor, witnesses, and treating physician; especially if the claimant is not certain of data such as time and date of injury, place injury occurred, or circumstances surrounding the injury.

QUESTION 18: Review statements of witnesses and the claimant's description of how the injury occurred on the Form CA-1. If no witnesses are listed on the Form CA-1, identify and interview individuals who might have witnessed the injury or raised questions concerning the plausibility of the claimant's statement. Discuss the possibility that the claimant may have influenced others to support the claim even though they did not actually witness the incident.

QUESTION 19: Claimants may provide false information on documents when initiating a claim, alter information provided by supervisors and witnesses, or make false statements to OWCP. Also, a claimant may have access to physician reports and alter medical information pertaining to severity of injury, the manner in which it occurred, and the effect it will have on future job performance. These forms could also be acquired independently and forwarded to OWCP with false information or forged physician's signature. Attach questionable documents to cases referred for investigation.

QUESTION 20: Compare statements of claimant, supervisor, witnesses, and treating physician; especially, if claimant is not certain of such data as time and date of injury, place injury occurred, or circumstances surrounding the injury.

QUESTION 21: Review statements of witnesses and claimant's description of how the injury occurred on the Form CA-1. If no witnesses are listed on the Form CA-1, identify and interview individuals who might have witnessed the injury or raised questions concerning the plausibility of the claimant's statement. Discuss the possibility that the claimant may have influenced others to support the claim even though they did not actually witness the incident.

Figure 53. Sample Statement of Recovery with Instructions

STATEMENT OF RECOVERY

CLAIMANT: John J. James FILE NUMBER: A12-0123456

DATE OF INJURY/DEATH: 6-30-90 EMPLOYING AGENCY: 1111AA

(1) Gross Recovery	$ 955,000
(2) Less Property Damage	0
(3) Balance	955,000
(4) Less Attorney's Fee (Fee is 40% of line 3)	(382,000)
(5) Balance	573,000
(6) Less Court Costs (Must be itemized)	24,784
(7) Balance (Adjusted Gross Recovery)	548,216
(8) Less 1/5 (20% of line 7)	(109,643)
(9) Balance	438,573
(10) Less Payment to Public Health Service (or other Federal medical facility)	0
(11) Balance	438,573
(12) Less Medical Expenses Paid by the Claimant	0
(13) Balance	438,573
(14) OWCP Disbursements (including compensation and medical but excluding COP) or line 13 above, whichever is less	111,430

Figure 53. Sample Statement of Recovery with Instructions, Continued

(15)	Less Government Allowance for Attorney's Fee (retained by claimant)	44,572
(16)	New OWCP Refund	66,858
(17)	Surplus (line 13 less line 14)	327,143

Figure 53. Sample Statement of Recovery with Instructions, Continued

INSTRUCTIONS

Distribution must be made in accordance with 5 U.S.C. 8132.

PROPERTY DAMAGE (Line 2) A reasonable amount for clothing or other personal belongings damaged or destroyed in an accident may be deducted. These amounts should be itemized. If an automobile or other vehicle is damaged or destroyed, furnish the year, make and model, and the Blue Book value of the vehicle. A copy of the repair bill will suffice if the vehicle was not totally destroyed.

ATTORNEY'S FEE (Line 4) The attorney's fee in line 4 is deducted from the balance shown in line 3. Also, the attorney's fee as a percentage of line 3 should be shown.

COURT COSTS (Line 6) These would consist only of such items as filing fees, witness fees, actual costs of collection, or any payments to physicians for expert testimony as opposed to payment for treatment. (Payment for medical treatment would come under line 12 and/or 14.) All items must be itemized.

20 Percent GUARANTEE (Line 8) The amount is turned over to the claimant and is not subject to any deductions.

PUBLIC HEALTH SERVICE (Line 10) Refund made to a Federal medical facility for treatment would be deductible under line 10. The claim of the Federal medical facility is separate and apart from the claim of the OWCP.

MEDICAL EXPENSE PAID DIRECT (Line 12) This would consist of any medical expenses paid by the claimant other than those paid by the OWCP or by an insurance carrier. It would not include items paid by the claimant and subsequently reimbursed by the OWCP or an insurance carrier. All items submitted for credit and deduction in line 10 must be itemized or accompanied by copies of paid bills. A lump sum amount will not be accepted for credit. The total OWCP disbursement is subject to the refund provisions of the Federal Employees' Compensation Act. However, if the balance remaining in line 14 is less than the actual OWCP disbursement, then the refund provision would apply to the amount shown on line 14.

GOVERNMENT ALLOWANCE FOR ATTORNEY'S FEE (Line 15) The Government contributes a portion of its refund to the claimant as an attorney's fee.

Figure 53. Sample Statement of Recovery with Instructions, Continued

This fee is based upon the OWCP's disbursement or other amount as shown in line 14 and is computed by applying the percentage shown in line 4 to line 14 if line 4 is considered reasonable.

TOTAL REFUND (Line 16) This represents the amount to be refunded to the Government for OWCP disbursements.

SURPLUS (Line 17) This surplus, which is retained by the claimant, is the amount against which the OWCP will credit any future compensafion payments or additional medical expenses payable on account of the same injury or death.

The refund check for the amount shown in line 16 should be made payable to "U.S. Department of Labor, OWCP." It should be sent to the following address:

U.S. Department of Labor
Appropriate Lockbox Address

Figure 54. Sample Letter Requesting Change of Chargeback Numbers

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Request for Change of Chargeback Account Number

TO: DoD Servicing Liaison

Dear (DoD Liaison's Name):

Please change the chargeback billing account codes for the following claims(s).

Name	SSN:	Claim Number	From	To
Jones, Janice E.	368-21-5786	A-060100100	3026XR	3076XF
Smith, Arlette A.	285-88-9674	A-060100100	3026XR	3076XF
Black, Jane E.	385-92-0688	A06-0300300	3026XR	3076XF

This request for change has been coordinated with Ms. Jane Green, Injury Compensation Program Administrator for the Defense Contract Management District South (DCMDS), account 3076XF.

If you have any questions, please call me at (100) 222-3333 or Ms. Keyes at (200) 333-4444. Thank you for your assistance in this matter.

Sincerely,

MARVIN B. BROWN
Injury Compensation Program
Administrator

cc: DCMDS (Ms. Green)

(NOTE: Coordination with the gaining activity is mandatory.)

Figure 55. Sample Letter Requesting Assistance

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Request for Assistance

TO: DoD Servicing Liaison

1. The action designated below is requested for:

(Case Number)_____

(Claimant's Name)_____

(Date of Injury)_____

_____ Provide a copy of the most recent medical report in the case file.

_____ Provide a copy of the CA 1/2 for ownership verification.

_____ Provide current case status; specifically:

_____

_____

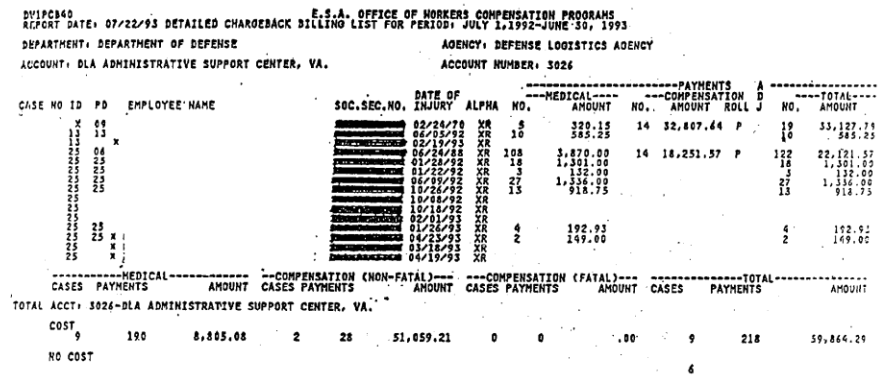
_____

2. Your assistance is appreciated. If you have any questions, please call me at (614) 522-0001.

MARVIN B. BROWN
Injury Compensation Program
Administrator

Figure 56. Example of Detailed Chargeback Billing List with Explanations

Example of Detailed Chargeback Billing List with Explanation



DU1PCB40 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS
REPORT DATE: 07/22/93 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1992-JUNE 30, 1993
DEPARTMENT: DEPARTMENT OF DEFENSE AGENCY: DEFENSE LOGISTICS AGENCY
ACCOUNT: DLA ADMINISTRATIVE SUPPORT CENTER, VA. ACCOUNT NUMBER: 3026

CASE NO	ID	PD	EMPLOYEE NAME	SOC.SEC.NO.	DATE OF INJURY	ALPHA	PAYMENTS ---MEDICAL--- NO.	AMOUNT	---COMPENSATION--- NO.	AMOUNT	A D ROLL J	TOTAL NO.	TOTAL AMOUNT
X	69				02/24/70	XR	4	320.15	14	32,807.44	P	19	33,127.71
13	13				06/05/92	XR	10	585.25				10	585.25
13		X			02/19/93	XR							
25	06				06/24/88	XR	108	3,870.00	14	18,251.57	P	122	22,121.57
25	25				01/28/92	XR	18	1,301.00				18	1,301.00
25	25				01/22/92	XR	3	132.00				3	132.00
25	25				06/09/92	XR	27	1,336.00				27	1,336.00
25	25				10/26/92	XR	13	918.75				13	918.75
25					10/08/92	XR							
25					10/18/92	XR							
25					02/01/93	XR							
25	25				01/26/93	XR	4	192.93				4	192.93
25	25	X			04/23/93	XR	2	149.00				2	149.00
25		X			03/18/93	XR							
25		X			04/19/93	XR							

	MEDICAL CASES	MEDICAL PAYMENTS	MEDICAL AMOUNT	COMPENSATION (NON-FATAL) CASES	COMPENSATION (NON-FATAL) PAYMENTS	COMPENSATION (NON-FATAL) AMOUNT	COMPENSATION (FATAL) CASES	COMPENSATION (FATAL) PAYMENTS	COMPENSATION (FATAL) AMOUNT	TOTAL CASES	TOTAL PAYMENTS	TOTAL AMOUNT
TOTAL ACCT: 3026-DLA ADMINISTRATIVE SUPPORT CENTER, VA.												
COST	9	190	8,805.08	2	28	51,059.21	0	0	.00	9	218	59,864.29
NO COST										6		

EXPLANATION OF CHARGEBACK BILLING LIST COLUMNS

1. Case No: Injury claim identification number assigned by OWCP.

2. ID: Initiating District Office. This number will always remain the same. It identifies the OWCP District Office where the claim was originally filed and where the case was "created."

3. PD: Paying District. Identifies the current paying OWCP District Office. Normally, the office where the case file can be located and where correspondence regarding the claim should be sent.

4. Employee Name: Self-Explanatory. An asterisk to the left of the employee's name indicates the first time the case appears on the listing. All cases have asterisks in the first quarter of each billing year.

5. SSN: Where Social Security Number is not available, 1s, 2s, 9s, or zeros are printed. Obtain the employee's SSN and notify OWCP.

6. Date of Injury: Self-Explanatory.

7. ALPHA: The two-letter alpha code that represents the employee's servicing COP (or Agency reporting office) that sent the claim to OWCP.

Figure 56. Example of Detailed Chargeback Billing List with Explanations, Continued

8. Payment Columns: Number of payments and total amount of payment. Medical includes payments for medical treatment, prosthetic devices and rehabilitation costs. Compensation Roll indicates the payment roll from which the last payment was made: D = Death; P = Periodic Nonfatal; S = Supplementary (Death, Periodic Nonfatal or Daily Nonfatal). Periodic roll cases are paid every four weeks plus any CPIs granted in a given fiscal year.

9. Account Totals: The number of payments and dollar costs under the medical and compensation categories will add horizontally to the payment and cost totals. The case totals under these columns will not. However, cases shown under the total column represent an unduplicated (actual) case cost.

NOTE:

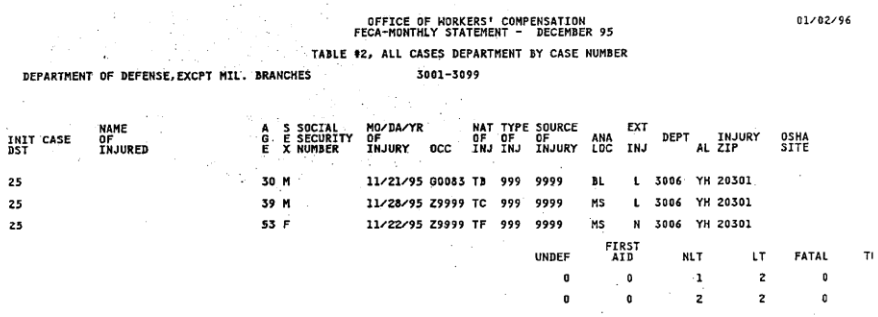
1. The total case count is broken out by total cost cases and total no cost cases.

2. The total number of fatal cases equals the number of "Ds" listed to the right of compensation roll payments.

3. A minus sign to the right of a payment amount indicates repayment or credit to the account. (Example - Recoupment of an overpayment, third-party recovery, etc.)

Figure 57. FECA Monthly Statements with Explanations

FECA Monthly Statements with Explanation



OFFICE OF WORKERS' COMPENSATION 01/02/96
FECA-MONTHLY STATEMENT - DECEMBER 95

TABLE #2, ALL CASES DEPARTMENT BY CASE NUMBER

DEPARTMENT OF DEFENSE,EXCPT MIL. BRANCHES 3001-3099

INIT DST	CASE	NAME OF INJURED	AGE	SEX	SOCIAL SECURITY NUMBER	MO/DA/YR OF INJURY	OCC	NAT OF INJ	TYPE OF INJ	SOURCE OF INJURY	ANA LOC	EXT INJ	DEPT	AL	INJURY ZIP	OSHA SITE
25			30	M		11/21/95	G0083	TB	999	9999	BL	L	3006	YH	20301	
25			39	M		11/28/95	Z9999	TC	999	9999	MS	L	3006	YH	20301	
25			53	F		11/22/95	Z9999	TF	999	9999	MS	N	3006	YH	20301	

UNDEF	FIRST AID	NLT	LT	FATAL	TI
0	0	1	2	0	
0	0	2	2	0	

EXPLANATION OF FECA MONTHLY STATEMENT COLUMNS

1. INST DST (ID). OWCP District Office where the claim was initially filed. This code will always be part of the unique case number.

2. CASE. Injury claim case number of the case. The ID number plus serial number makes the unique case number. Example 03-0501111 or A3-0501111.

3. NAME OF INJURED. Last name of injured employee.

4. First initial of injured employee.

5. AGE. Age of the employee on the date of injury.

6. SEX. Self-explanatory.

7. SOCIAL SECURITY NUMBER. If the SSN column contains 1s, 2s, 9s, or zeros, the SSN is not available at OWCP. Obtain the employee's correct SSN and notify OWCP.

8. MO/DA/YR of Injury. Date of Injury (DOI).

9. OCC. The employee's occupation on DOI.

10. NAT OF INJ. Nature of Injury. See Figure SC810.F67. to determine the extent of injury. Example: T9 = Traumatic Injury Unclassified.

11. TYPE OF INJ and SOURCE OF INJURY. The type code stands for an action and the source code for an object or substance. Together, they form a brief description of how the incident occurred. (See OSHA publication 2014.)

12. ANA LOC. Anatomical Location of Injury. See Figure SC810.F68. to determine part of body that was injured. Example: 5K = Single knee.

13. EXTENT OF INJURY. See Figure SC810.F69. to determine the extent of injury. Example: X = Nonfatal lost time.

14. DEPT. Code representing the Agency that will be billed back for any expenses incurred.

15. AL. Two letter alpha codes designates the employee's servicing civilian personnel office or Agency reporting office.

16. UNDEF. Undefined.

17. FIRST AID. No lost time or medical expense.

18. NLT. No lost time.

19. LT. Lost time.

20. FA. Fatal.

NOTES:

1. Where appropriate, copies of the Table #2 statements should be provided to the activity Safety Office. Each case listed represents a "Case Create" and data contained thereon is needed to determine local injury rates.

2. Identification and quick correction of chargeback code errors will prevent erroneous charges from appearing on DOL chargeback bill.

Figure 58. Occupational Codes

LIST OF OCCUPATIONAL CODES

01	Aeronautics Engineer	50	Mason
02	Ash and Trash Collector	51	Meat Cutter
03	Blacksmith	52	Meat Inspector
04	Boilermaker	53	Mechanic Repairman
05	Brakeman	54	Mechanical Engineer
06	Heavy Equipment Operator	55	Melter
07	Air Traffic Controller	56	Mess Attendant
08	Carpenter	57	Messenger, Not Post Office
09	Charwoman	58	Mimeograph Operator
10	Chauffeur	59	Molder
11	Checker	60	Munition Handler
12	Chemical Engineer	61	Nurse
13	Chipper and Caulker	62	Office Worker
14	Civil Engineer	63	Oiler
15	Cook	64	Operating Engineer
16	Reader	65	Packer
17	Carrier, Rural Mail	66	Painter
18	Core Maker	67	Patrolman
19	Crane Operator	68	Pattern Maker
20	Crater	69	Pile Driver
21	Doctor; Dentist	70	Pipe Coverer
22	Draftsman; Tracer	71	Pipe Fitter
23	Driver, Mechanic	72	Plasterer
24	Electrical Engineer	73	Plumber
25	Electrician, Lineman	74	Pressman
26	Elevator Operator	75	Printer
27	Engineering Aid or Helper	76	Radio Engineer
28	Firefighter	77	Railroad Worker
29	Fireman	78	Railway Postal Personnel
30	Fleet Workman	79	Rigger
31	Foreman	80	Safety Engineer
32	Forester	81	Sand Blaster
33	Forest Ranger	82	Seaman Crew Member
34	Forklift, Tub, Tractor Operator	83	Sewer
35	Guard	84	Sheetmetal Worker
36	Inspector	85	Shipfitter

Figure 58. Occupational Codes, Continued

LIST OF OCCUPATIONAL CODES--Continued

37	Instrument Worker	86	Shipweight
38	Investigator	87	Soil Conservationist
39	Iron Worker	88	Stationary Engineer
40	Janitor	89	Stock Clerk
41	Laboratory Worker	90	Storekeeper
42	Laborer	91	EAM Operator
43	Launder Worker	92	Tool Maker
44	Lockman	93	Truck Driver
45	Longshoreman	94	Veterinarian
46	Machinist	95	Warehouseman, Freight Handler
47	Carrier, City Mail	96	Ward Attendant
48	Mail Clerk	97	Welder
49	Mail Handler	98	Teacher
		99	Other Occupation

Figure 59. Nature of Injury Codes with Explanation

NATURE OF INJURY CODES
EXPLANATION OF OWCP'S METHOD OF ASSIGNING NATURE OF INJURY CODES

(T) Traumatic Injury or Disability (and Incident)*
TA Amputation
Th Back Strain
TC Contusion, bruise, abrasion
TD Dislocation
TP Fracture
Th Hernia
TK Concussion
TL Laceration; cut
TP Puncture
TS Strain, multiple
TU Burn, scald, sunburn
TI Traumatic Skin Diseases/conditions including dermatitis
TR Traumatic Respiratory disease
TQ Traumatic Food Poisoning
TW Traumatic Tuberculosis
TX Traumatic Virological/infective Parasitic Diseases
T1 Traumatic Cerebral Vascular condition; stroke
T2 Traumatic Hearing Loss
T3 Traumatic Heart Condition
T4 Traumatic mental disorder; emotional stress; nervous condition
T8 Traumatic Disability; other

R Respiratory Disease
RA Asbestosis
RB Bronchitis
RE Emphysema
RP Pneumonconiosis
RS Silicosis
R9 Respiratory Disease, unclass.
V Virological, Ineffective and Parasitic Diseases
VB Brucellosis
VC Coccidioidomycosis
VF Food poisoning
VH Hepatitis
VM Malaria
VS Staphylococcus
VT Tuberculosis
V9 VirologicalIInfective/ Parasitic - UnClass.
D Disability, Occupational
DA Arthritis; bursitis
DB Back strain; back sprain
DC Cerebral vascular condition; Stroke
DD Endemic disease (other than P and S, above)
DE Effect of Environmental

Figure 59. Nature of Injury Codes with Explanation, Continued

NATURE OF INJURY CODES
EXPLANATION OF OWCP'S METHOD OF ASSIGNING NATURE OF INJURY CODES--Continued

T9 Traumatic Injury-unclass. (except disease, disability, illness)	DH Hearing Loss
S Skin Disease or Condition	DK Heart condition
SB Biological	DM Mental disorder; emotional stress; nervous condition
SC Chemical	DR Radiation
S9 Dermatitis, unclass.	DS Strain, multiple
	DU Ulcer
	DV Other vascular conditions
	D9 Disability, unclass.

* Injury or condition must be caused by a specific incident or event which occurred during a single workday or shift.

The Nature of Injury Codes help OWCP classify reported injuries for computerized statistical analysis and reporting. Also, the ICPA uses Nature of Injury Codes to classify traumatic versus non-traumatic cases in their currently in use internal management information reports. Normally, OWCP assigns the Nature of Injury Code on the basis of information reported on Form CA-1, Block 14 or on Form CA-2, Block 14. Sometimes, however, it is necessary to review other information reported on these, or accompanying forms and documents, to accurately identify and code the nature of the reported injury. This is especially true when dealing with certain categories of injuries, which usually result from a long series of exposures, but which could also result from a single such exposure or episode of exposures (for example, poison ivy, traumatic hearing loss). Most often this distinction can be made on the basis of information contained on Form CA-1, Block 13 or on Form CA-2, Blocks 12 and 13.

Figure 60. Anatomical Codes

ANATOMICAL LOCATION OF INJURY CODES

	Code	Value
Arm/wrist	AB	Arm and wrist
	AS	Arm or wrist
Trunk, external musculature	B1	Single breast
	B2	Both breasts
	B3	Single testicle
	B4	Both testicles
	BA	Abdomen
	BC	Chest
	BL	Lower back
	BP	Penis
	BS	Side
	BU	Upper back
	BW	Waist
	BZ	Not otherwise classified
Head internal	C1	Single ear (internal)
	C2	Both ears (internal)
	C3	Single eye (internal)
	C4	Both eyes (internal)
	CB	Brain
	CC	Cranial bones
	CD	Teeth
	CJ	Jaw
	CL	Throat; larynx
	CM	Mouth
	CN	Nose
	CR	Throat; other
	CT	Tongue
	CZ	Not otherwise classified
Elbow	EB	Both elbows
	ES	Single elbow
Finger	F1	Single first finger
	F2	Both first fingers
	F3	Single second finger
	F4	Both second fingers
	F5	Single third finger
	F6	Both third fingers
	F73	Single fourth finger
	F8	Both fourth fingers

Figure 60. Anatomical Codes, Continued

ANATOMICAL LOCATION OF INJURY CODES--Continued

	Code	Value
Toe	G1	Single great toe
	G2	Both great toes
	G3	Single other toes
	G4	Multiple other toes
Head, external	H1	Single eye, (external)
	H2	Both eyes (external)
	H3	Single ear (external)
	H4	Both ears (external)
	HC	Chin
	HF	Face
	HK	Neck/throat
	HM	Mouth/lips
	HN	Nose
	HS	Scalp
Knee	KB	Both knees
	KS	Single knee
Leg, hip, ankle, buttock	LB	Both legs/hips/ankles/buttocks
	LS	Single leg/hip,ankle/buttock
Hand	MB	Both hands
	MS	Single hand
Foot	PB	Both feet
	PS	Single foot
Trunk, bones	R1	Single clavicle (collar bone)
	R2	Both clavicles (collar bone)
	R3	Single scapula (shoulder blade)
	R4	Both scapula (shoulder blades)
	RB	Rib
	RS	Sternum (breast bone)
	RV	Vertebrae (spine; disc)
Shoulder	RZ	Trunk, bones unclass.
	SB	Both shoulders
	SS	Single shoulder
Thumb	TB	Both thumbs
	TS	Single thumb

Figure 60. Anatomical Codes, Continued

ANATOMICAL LOCATION OF INJURY CODES--Continued

	Code	Value
Trunk, internal	VH	Heart organs
	V1	Lung, single
	V2	Lung, both
	V3	Kidney, single
	V4	Kidney, both
	VL	Liver
	VS	Stomach
	VV	Intestines
	VR	Reproductive organs
	VZ	Trunk, internal unclass.

Figure 61. Extent of Injury Codes

EXTENT OF INJURY

No Lost Time.....1	Inoculation.....8
Nonfatal Lost Time.....X	Fatal.....0

NOTES:

1. A lost time injury is one in which disability for work extends beyond the date of injury.

2. The Extent of Injury is assigned to traumatic injury cases based on a review of Form CA-1, Blocks 21 (Date of Injury), 23 (Date and Hour Stopped Work) and 26 (Date and Hour Employee Returned to Work). If the employee did not stop work, or stopped work on the date of injury, but returned at the start of the next day's workshift, OWCP would code this No Lost Time. A case should receive a Lost Time code only if the work stoppage extended beyond the date of injury.

3. The ICPA should leave Form CA-1, Block 23 (Date and Hour Stopped Work) blank, unless work stoppage extends or is expected to extend beyond the date of injury.

Figure 62. Fatal Indicator Codes

Figure SC810.F70. Fatal Indicator Codes

FATAL INDICATOR CODES

0 = Deceased, not injury related.

1 = Death immediate or simultaneous with injury.

2 = Later fatal, subsequent to injury.

Figure 63. Sample Letter from OWCP Requesting Transfer of Health Benefits

REQUEST FOR TRANSFER OF FEHB ENROLLMENT TO OWCP

U.S. Department of Labor

Employment Standard Administration
Office of Worker's Compensation Programs
Division of Federal Employees Compensation
Washington, DC 20210

REQUEST FOR TRANSFER OF FEHB ENROLLMENT TO OWCP

Employing office name and address:

Date of request:
File number:
Employee's name:
Social Security Number:
Effective date of transfer:

The above-named employee is receiving compensation under the Federal Employee's Compensation Act and we are withholding premiums for the employee's Federal Employees Health Benefits (FEHB) Program enrollment from the employee's compensation.

Please forward the employee's health benefits enrollment documents to this Office as specified in the Federal Employees Health Benefits Handbook (formerly the Supplement 890-1 of the Federal Employees Personnel Manual). The documents include the copies of every SF 2809 and SF 2810 in the employee's Official Personnel Folder beginning with the date of his or her initial enrollment in the FEHB Program, together with any related documentation (such as medical documentation for a disabled child over age 22). As of the effective date shown above, OWCP is the employing office for this employee.

If you have sent the employee's OPF to the Federal Records Center, it is your responsibility to recall it so that you can comply with this request.

If you have any questions concerning this request, you may contact:
Name of contact:
Telephone number:

Figure 63. Sample Letter from OWCP Requesting Transfer of Health Benefits, Continued

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To be completed by employing office

Employing office: Attached documents to this form and return to OWCP. File a copy of the form in the employee's OPF to show the disposition of the FEHB documents.

Name of employing office contact: Telephone number: Date documents sent OWCP:

_____ _____ _____

Figure 64. Sample Letter Forwarding Health Benefits to OWCP

TRANSFER OF FEHB ENROLLMENT TO OWCP

OWCP District Office name and address:

Date of request:
OWCP file number:
Employee's name:
Social Security Number:
Effective date of transfer:

The above-named employee is receiving compensation under the Federal Employee's Compensation Act and OWCP is withholding premiums for the employee's Federal Employees Health Benefits (FEHB) Program enrollment from the employee's compensation.

Attached are the employee's health benefits enrollment documents, which this Agency is forwarding to OWCP as specified in the Federal Employees Health Benefits Handbook. The documents include the copies of every SF2809 and SF 2810 in the employee's Official Personnel Folder beginning with the date of Initial enrollment in the FEHB Program, together with any related documentation (such as medical documentation for a disabled child over age 22). As of the effective date shown above, OWCP is the employing office for this employee.

The reason for this action is:

{ } This employee is separating (or has separated on) _____.
(date)

{ } This employee will complete 365 days in nonpay status on _____.
(date)

Figure 64. Sample Letter Forwarding Health Benefits to OWCP, Continued

If you have any questions concerning this transfer, you may contact:

Name of contact:
Telephone number:

Sincerely,

MELVIN A. BROWN
Injury Compensation
Administrator

(Added)(DAF) ACRONYMS

AD&D	**Accidental Death and Dismemberment**
AFPC/ICO	**Air Force Personnel Center/Injury Compensation Office**
ASHD	**Arteriosclerotic Heart Disease**
CPMS	**Civilian Personnel Management Service**
COP	**continuation of pay**
CPO	**Civilian Personnel Office**
CPS	**Civilian Personnel Section**
CSRS	**Civil Service Retirement System**
DASC	**Direct Air Support Center**
DeCA	**Defense Commissary Agency**
DefPAC	**Defense Portal Analysis Center**
DFAS	**Defense Finance and Accounting Services**
DIUCS	**Defense Injury & Unemployment Compensation System**
DOL	**Department of Labor**
ECAB	**Employees' Compensation Appeals Board**
ECOMP	**Employees' Compensation Operations & Management Portal**
EDI	**Electronic Data Interchange**
EMF	**Employee Medical File**
FECA	**Federal Employees' Compensation Act**
FEGLI	**Federal Employees' Group Life Insurance**
FEHB	**Federal Employees' Health Benefits**
FERS	**Federal Employees' Retirement System**
HRO	**Human Resources Office**
IC	**Injury Compensation**
ICPA	**Injury Compensation Program Administration**
ICS	**Injury Compensation Specialist**
ICUC	**Injury Compensation and Unemployment Compensation**
LWEC	**Loss of Wage-Earning Capability**
LWOP	**leave without pay**
MAJCOM	**Major Command**
OPF	**Official Personnel File**
OPR	**Office of Primary Responsibility**
OPM	**Office of Personnel Management**
OSHA	**Occupational Safety and Health Agency**
OWCP	**Office of Workers' Compensation Programs**
NPRC	**National Personnel Records Center**
PN	**Periodic Roll, No Wage Earning Capacity**
RIF	**Reduction in Force**
ROTC	**Reserve Officers Training Corps**
RS	**Rehabilitation Specialist**
RTD	**return to duty**
TCC	**Temporary Continuation of Coverage**
UIC	**Unit Identification Code**
U.S.C.	**United States Code**
VRA	**Veterans Re-Adjustment Act**
VSIP	**Voluntary Separation Incentive Program**
WEC	**wage earning capacity**

GLOSSARY
DEFINITIONS

These terms and their definitions are for the purposes of this Volume.

attendant allowance. Additional money provided to an employee who has been so severely injured that he or she is unable to care for his or her own physical needs such as feeding, bathing, or dressing. This is payable in addition to compensation for wage loss.

(Added)(DAF) challenge. The formal administrative procedure through which DAF supervisors or the servicing ICS present evidence to OWCP to challenge an employee's claim for benefits. Any challenge must be thoroughly documented and submitted to the DOL at the earliest date the facts are available. (T-3).

chargeback. The system of Department of Labor (DOL) billing the Department of Defense for payments related to the Office of Workers' Compensation Program (OWCP)-approved claims and then the Department o Defense charging those costs to the employing agency, or as otherwise established by DoD chargeback policy.

Civilian Personnel Office/Human Resources Office (CPO/HRO). The local operating personnel office.

(Added)(DAF) Civilian Personnel Section (CPS). Synonymous with CPO/HRO.

claimant. An individual whose claim for entitlement to benefits under the Federal Employees' Compensation Act (FECA) has been filed according to the provisions of FECA.

claims examiner. An employee of the OWCP possessing special training and experience in claims adjudication.

compensation. Benefits paid or payable under FECA, including money paid because of loss of wages, medical expenses, rehabilitation expenses, loss of use of major body functions, as well as death benefits to survivor(s).

continuation of pay (COP). Continuation of regular pay to a traumatically injured employee with no charge to sick or annual leave for the first 45 calendar days of disability. COP is subject to taxes and all other usual payroll deductions.

controversion. The formal administrative procedure through which DoD management presents evidence to OWCP to challenge an employee's claim for benefits. Management may controvert claims for COP that are clearly in conflict with the provisions of the regulations, or if there is serious doubt as to the validity of the claim. Controversions must be thoroughly documented and submitted at the earliest date the facts are available.

Defense Injury/Unemployment Compensation System (DIUCS). The automated injury compensation database used by DoD injury compensation professionals to manage claims and

validate costs.

Defense Portal Analysis Center (DefPAC). A secure information base for ICPA's. Provides a virtual library of references and links for Injury Compensation program management such as: Regulations and procedure manuals, ECAB decisions, OWCP forms, Systems links, Statistical reports specific to the agency, and Tutorials.

dependent. Include a wife or husband; an unmarried child under 18 years of age or, if over 18, incapable of self support because of a physical or mental disability; or a student under 23 years of age who has not completed 4 years of education beyond the high school level; a parent, dependent on and supported by the employee.

DoD Injury Compensation Liaisons. A member of the Civilian Personnel Management Service (CPMS) who is co-located with OWCP district offices. Liaisons provide technical assistance in the FECA program to all serviced activities.

Electronic Data Interchange (EDI). The technical solution that allows Defense activities to complete CA-1 and CA-2 forms online and submit them via the internet to the ICPA.

employee. An individual who fits within one of the following listed groups: (1) A civil officer or employee in any branch of the Government of the United States; (2) An individual rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service, or authorizes payment of travel or other expenses of the individual; (3) An individual other than an independent contractor or an individual employed by an independent contractor, employed on the Menominee Indian Reservation in Wisconsin in operations conducted under a statute relating to tribal timber and logging operations on that reservation; (4) An individual appointed to a position on the office staff of a former President; or (5) An individual selected and serving as a Federal petit or grand juror.

Employees' Compensation Appeals Board (ECAB). An entity separate from the OWCP that gives government employees the same administrative due process of law and the right of appellate review which most non-government workers enjoy under workers' compensation laws of the various states.

Federal Employees' Compensation Act (FECA). Outlines the statutory regulations for the workers' compensation program which is identified in 5 USC 8101 et seq as amended in 1974.

(Added)(DAF) Federal Employees' Compensation Act Working Group. An installation level advisory group comprised of commanders and other staff who have authority to speak for their organizations regarding the Injury Compensation Program and initiatives/processes that may result in reduction of injuries, illnesses and occupational diseases associated with certain positions.

fraud. An intentional deceptive act, or series of acts, committed by an individual with the specific intent to cause the DoD or OWCP to grant benefits under FECA which would normally not be granted.

Injury Compensation Program Administrator (ICPA). The individual designated by the Civilian

Personnel Officer who oversees and is responsible for the Injury Compensation Program.

(Added)(DAF) Injury Compensation Specialist. Members of the Air Force Personnel Center, Injury Compensation Office (AFPC/ICO) who are responsible for the management and administration of the DAF IC program. For the purpose of this publication, the term is synonymous with ICPA.

leave buy-back. A procedure whereby an employee may have leave restored to his or her account if it was initially used due to a job-related injury.

light duty. The temporary or permanent assignment to productive duty of an employee who is partially disabled from a job-related injury or illness and is unable to perform his or her regularduties. The employee's return to work must be recommended by appropriate medical authority and the assigned tasks must be fully consistent with the physical limitations specified by such medical authority.

loss of wage earning capacity (LWEC). Compensation benefits paid at a reduced rate, based on an employee's ability to earn normal wages due to partial disability which is job-related.

(Added)(DAF) lost days. Any day, charged to continuation of pay or leave without pay, due to a workplace injury, illness or occupational disease, during the first year after injury, illness or disease.

(Added)(DAF) medical documentation. A medical statement or written documentation from a person meeting the definition of a "physician" that provides information required to support a claim for compensation benefits. For purposes of reasonable accommodation, medical documentation is not limited to that provided by a physician, but may come from "an appropriate health care or rehabilitation professional." The appropriate professional in any particular situation will depend on the disability and the type of functional limitation it imposes. Appropriate professionals include, but are not limited to, doctors (including psychiatrists), psychologists, nurses, physical therapists, occupational therapists, speech therapists, vocational rehabilitation specialists, and licensed mental health professionals.

occupational disease or illness. An illness or disease produced by: systemic infections, conditions or repeated stress or strain, exposure to toxins, poisons, fumes, or other continued and repeated exposure to the work environment over a period greater than a single day or work shift. Persons suffering from occupational diseases are limited to injury compensation payments provided by FECA or to sick or annual leave.

Office of Workers' Compensation Programs (OWCP). The Office of the Department of Labor that has overall responsibility for administration of FECA.

(Added)(DAF) Office of Workers' Compensation Programs District Offices. The 12 district offices established by the Office of the Department of Labor to manage Federal Employees' Compensation Act claims. The district offices are organized to cover distinct geographic areas and serve as the official repositories of Federal Employees' Compensation Act claim case files.

partial disability. Cases where an employee's injury or illness precludes return to regular duty,

but is not totally disabling for all work.

periodic roll. A system used by OWCP whereby the U.S. Treasury pays prolonged disability cases and death cases each 28 days, automatically until advised otherwise by OWCP.

(Added)(DAF) Physician. Includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors within the scope of their practice as defined by state law. Naturopaths, faith healers, and other practitioners of the healing arts are not recognized as physicians.

physician's assistant. A para-professional with special training in primary health care services, who works under the supervision of a physician. For purposes of FECA, an opinion rendered by a physician's assistant is not acceptable medical evidence, unless countersigned by the physician.

Pipeline Reemployment Program. Provides temporary funding and over hire authority of positions established for employees and former employees in receipt of workers' compensation benefits. Requests for pipeline benefits are approved by the DoD.

reasonable accommodation. Reasonable accommodation may include, but shall not be limited to: (1) making facilities readily accessible to and usable by handicapped persons; and, (2) job restructuring, part-time or modified work schedules, acquisition or modification of equipment or devices, appropriate adjustment or modification of examinations, the provision of readers and interpreters; and, other similar actions such as flexiplace employment.

recurrence. After returning to work, an injured employee is again disabled and stops work as a result of the original injury or occupational disease. A work stoppage is not a recurrence of disability if it is caused by a condition that results from a new incident of injury even to the same portion of the body previously injured, or from a new exposure to the cause(s) of a previously suffered occupational disease.

rehabilitation. Services and/or training provided to an injured employee who suffers from a vocational handicap due to a work-related injury or illness and who cannot resume usual employment. The goal is to successfully place the person in a job that they can perform within their limitations.

schedule awards. Compensation provided for specified periods of time for the permanent loss or loss of use of each of certain members, organs, or functions of the body. Compensation for proportionate periods of time is payable for partial loss of use of each member or organ. The compensation for schedule awards will equal 66 2/3 percent of the employee's pay or 75 percent when there is a dependent. Schedule awards are payable even if a person is federally employed or receiving Federal retirement benefits for the period of the award.

termination of COP. Termination of COP can be accomplished for any of the nine reasons listed on Form CA-1 or if medical documentation of disability has not been received within 10 work days after the claim has been made for COP.

third-party cases. Cases in which persons or agencies other than the Federal government may be liable for the injury, illness or death of an employee.

total disability. When an employee is unable to work in any capacity, as a result of a job-related injury or illness.

traumatic injury. A wound or other condition of the body caused by external force, including stress or strain. It must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident, or series of events or incidents within a single day or work shift. For example, a strained back caused by lifting a heavy box would be a traumatic injury. Only traumatic injuries entitle employees to COP. Traumatic injuries include damage to or destruction of prosthetic devices or appliances. Eyeglasses and hearing aids are excepted, unless damaged or destroyed as a direct result of a job-related personal injury requiring medical attention.

waiting period. The first 3 days of total disability, during which time compensation is not payable. This occurs at the expiration of the COP period (or sick or annual leave). Nonwork days can be counted towards the 3 waiting days. Example: The 45th day of COP ends on Friday. Waiting days are Saturday, Sunday and Monday. The employee must be in a nonpay status. The waiting days requirement does not apply if the disability exceeds 14 days or permanent disability results. Waiting days also apply in occupational disease cases.