

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
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.

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 FICA 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 _____

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

Supervisor's Title _____

Office phone _____

Signature of supervisor _____

Date _____

Name of supervisor (Type or print) _____

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:

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

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

37. Pay rate when employee stopped work \$ _____ Per _____

Signature of Supervisor and Filing Instructions _____

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

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

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

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

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

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

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

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

20. Regular work hours From: a.m. _____ To: 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. _____

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.

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

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

ZIP Code _____

OSHA Site Code _____

OWCP Agency Code _____

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

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).

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.

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.

Employing Agency - Required Codes

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.

Form CA-1
Rev. Apr. 1999

U.S. GPO: 1999-1-484-172/04

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

At (Location)

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

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

Receipt of Notice of Injury

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. (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. (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. (6) 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. (5) 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. (4) Information may be disclosed to private-sector agencies 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. (3) Information may be verified through computer matches or other appropriate means. (2) 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. (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. 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. 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 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. (5) 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.

Privacy Act

- (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 derangement of the head, face, or neck.
- (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.
- (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 continues the employee's pay, the pay must not be interrupted unless one of the provisions outlined in 20 CFR 10.222 apply.
- (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.

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

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