

SUPERVISORS INSTRUCTIONAL GUIDE

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CHAPTER 1

GENERAL:

1-1. PURPOSE. The purpose of this guide is to provide the supervisor with detailed instructions on how to complete basic forms required to file for Workers' Compensation claims for an employee/technician. This also instructs the supervisor where to send completed forms. **All compensation forms must be typed or legibly written/printed.**

1-2. SCOPE. The provisions of this guide are applicable to all administrative offices, installations or activities that employ Army and/or Air National Guard Technicians. It pertains to all excepted, competitive and temporary technicians.

2-1. Form CA-1: Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. This is the basic form. The information contained on this form is used throughout the processing of a compensation claim. The dates are extremely important in establishing entitlement; therefore, correct and accurate completion of the form is a MUST.

2-2. Responsibility. It is the responsibility of the employee to notify his/her immediate supervisor that he/she has suffered a traumatic injury. This notification must be in writing and submitted within **ten (10) working days of the injury**. The employee completes the front portion of the CA-1, and it is the supervisor's responsibility to immediately complete the reverse side of the form.

2-3. Forwarding Form CA-1. The CA-1 must be forwarded to the OWCP Specialist, Human Resources Office (HRO), who will check for completeness and accuracy.

2-4. Instructions on Completing Form CA-1. The injured employee or a person acting on the employee's behalf must complete blocks 1 thru 16.

BLOCK 1 Employee's last name, first name, middle name or initial (enter "NMN" for no middle name).

BLOCK 2 Employee's social security number.

BLOCK 3 Date of birth (month, day and year).

BLOCK 4 Sex.

BLOCK 5 Home telephone number (include area code), if no home telephone, enter "NONE".

BLOCK 6 Employee's pay plan (GS, GM, WG, WL or WS), grade and step.

BLOCK 7 Complete home mailing address, include the zip code.

BLOCK 8 Check the appropriate box (a number is not required), If no dependents, "NONE" should be entered.

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BLOCK 9 Exact location of injury: identify room, building number and work area. (If off work site include street, city, state and zip code.) If employee was TDY when the injury occurred, a copy of the TDY orders must be attached.

BLOCK 10 Enter date and time that injury occurred, AM or PM. (**DO NOT USE MILITARY TIME.**)

BLOCK 11 Enter date of when this form was signed.

BLOCK 12 Employee's job title. (**Aircraft Mechanic, Heavy Mobile Equipment Repairer, etc., must be exactly what is on the SF-50.**)

BLOCK 13 Enter detailed description of how and why the injury happened. (Precise height employee fell, exact size/weight of item lifted, tripped/slipped; and what caused incident, i.e., ice on walkway, oil on floor, etc.)

BLOCK 13a To be completed by the OWCP Specialist in the HRO.

BLOCK 13b To be completed by the OWCP Specialist in the HRO.

BLOCK 13c To be completed by the OWCP Specialist in the HRO.

BLOCK 14 Describe the nature of injury and part(s) of the body injured.

BLOCK 15 Employee must select type of leave, at the time of the injury, even if there is no immediate time loss. The type of leave available is sick, annual or Continuation of Pay (COP)*.

* Continuation of Pay (COP): Under 5 U.S.C. 8118 of the Federal Employees' Compensation Act concerning Continuation of Pay, it states in part:

"If an employee returns to duty without using all forty-five (45) days of Continuation of Pay and then suffers a recurrence of disability he may elect to use the remaining days of continuation of pay if the recurrence occurs within ninety (90) days after first return to duty. If work stoppage for recurrence begins more than ninety (90) days after the employee first returned to work following the initial date of injury, the balance of the continuation of pay may not be paid."

BLOCK 16 If there was a witness, have the witness enter a statement in this block. If the space provided is insufficient, attach a separate sheet and enter "See attached statement" in block 16. The witness must include his/her name and address, signature and date. **If there were no witnesses, please enter: "There were no witnesses to this injury."**

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The supervisor is responsible to complete blocks 17 thru 38.

BLOCK 17 Enter the name and address of the reporting agency. The Adjutant General, WI, ATTN: WING-HR-MT, PO Box 8111, Madison, WI 53708-8111. **The OWCP Agency Code will be completed by the OWCP Specialist in the HRO.**

BLOCK 18 Enter the address of the injured employee's duty station (include zip code).

BLOCK 19 Enter employee's retirement coverage, CSRS, FERS, Other (identify).

BLOCK 20 Enter employee's regularly scheduled work hours.

BLOCK 21 Enter employee's regular work schedule. (Check what days he/she works.)

BLOCK 22 Enter date the injury occurred. If this does not agree with block 10, enter the reason in block 34 or on a separate statement.

BLOCK 23 Enter date the supervisory was notified or became aware of the injury.

BLOCK 24 Enter the date and time the employee first stopped work. This will be the actual time of injury or when the employee first seeks medical attention. If work did not stop, enter DID NOT STOP.

BLOCK 25 Only enter date when employee enters Leave Without Pay (LWOP), otherwise enter "N/A".

BLOCK 26 Enter date of COP. COP begins on the day after the injury took place or the first day of disability. If the employee is not eligible for COP, enter "Not Eligible". (An example is that Form CA-1 was submitted to the supervisor more than 30 calendar days after the injury.)

BLOCK 27 Enter date and time employee returned to work.

BLOCK 28 Check "YES" if employee was performing his/her technician duties. If the employee was not, check "NO" and explain.

BLOCK 29 This is usually checked "NO". Willful misconduct has to be documented and the employee had to be counseled at least three (3) times in the recent past two (2) months.

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BLOCK 30 If there is no evidence of a third party involved, check "NO". If evidence is presented that a third party was involved or responsible, check "YES" and enter the name and address of that individual in Block 30.

BLOCK 31 Enter the name and address person/party involved. Enter "N/A" if none applied.

BLOCK 32 The name and address of the treating physician who first provided medical treatment for the work related injury.

BLOCK 33 Refer to the most current medical reports and check appropriate block. If medical report is not available, enter "Unknown".

BLOCK 34 Refer to the most current medial reports and check appropriate block. If medical report is not available, enter "Unknown".

BLOCK 35 If you agree with the statement(s) provided by the employee and/or witness(es) check "Yes". When the supervisor has information which contradicts what the employee has provided, either verbal or written, check "NO".

BLOCK 36 If the information available supports the claim, check "NO" and advise the employee there will be no controversion. If there is evidence that either the claim or COP should be controverted, check "YES". Advise the employee of your intent and reason. If a decision cannot be made at the time this form is completed, enter "Decision to Controvert pending investigation". Coordinate any additional information or evidence with the OWCP Specialist in the HRO.

BLOCK 37 Enter the employee's pay rate that was in effect at the time of injury or when the employee stopped work.

BLOCK 38 Supervisor must sign, date, enter title and telephone number to include area code.

BLOCK 38 Check the appropriate block. One of these blocks MUST be checked.

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

3-1. Form CA-2: Notice of Occupational Disease and claim for Compensation. This form is for reporting a work related occupational disease. The dates on the form are

extremely important in establishing entitlements. Correct and accurate completion is extremely important.

3-2. Responsibility. It is the responsibility of the employee to notify his/ her immediate supervisor that he/she has an occupational disease. This notification must be in writing and submitted within 30 calendar days of when the employee first became aware of the disease. The employee completes the front portion of Form CA-2, and the supervisor completes the reserve side immediately. The supervisor notifies the employee that occupational disease cases are not entitled to Continuation of Pay (COP). Claims for compensation, relating to "Occupational Disease" are more complicated and the supervisor should contact the OWCP Specialist in the HRO for guidance.

3-3. Instructions on Completing Form CA-2. The employee, or person(s) acting on their behalf, must complete Blocks 1 thru 18.

BLOCK 1 Employee's last name, first name, middle name or initial (enter "NMN" for no middle name).

BLOCK 2 Employee's social security number.

BLOCK 3 Date of birth (month, day and year).

BLOCK 4 Sex.

BLOCK 5 Home telephone number (include area code), if no home telephone, enter "NONE".

BLOCK 6 Employee's pay plan (GS, GM, WG, WL or WS), grade (level) and step.

BLOCK 7 Complete home mailing address, include the zip code.

BLOCK 8 Check the appropriate box(es); however, if no dependents, "NONE" should be entered.

BLOCK 9 Enter employee's complete job title, should be exactly like what is on the SF-50.

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BLOCK 9a To be completed by OWCP Specialist in the HRO.

BLOCK 10 Enter complete address, include zip code, where the disease/illness developed.

BLOCK 11 Enter date the employee first became aware of the disease/illness. This may or may not be the same date when he/she realized it was caused or aggravated by his/her place of employment.

BLOCK 12 Enter date when employee realized the disease/illness was caused by Federal Employment. Employee must be very specific. IMPORTANT: Employee can be aware of the disease/illness without realizing it is work related. (See Block 11)

BLOCK 13 Enter the reasons why you feel your disease/illness is the result of your employment. (The supervisor must request the Occupational Disease Checklist, that shows what evidence is required to support the claim, from the OWCP Specialist in the HRO.)

BLOCK 14 Enter nature of the disease/illness.

BLOCK 14b To be completed by OWCP Specialist in the HRO.

BLOCK 14c To be completed by OWCP Specialist in the HRO.

BLOCK 15 If an entry is required, be very specific in the reason you provide.

BLOCK 16 With the CA-2, the employee must submit the following in narrative statement:

- a. A detail history of the disease/illness from the date it started.
- b. Complete details of the conditions of employment which are believed to be responsible for the disease/illness.
- c. A description of specific exposures to substances or stress conditions causing the disease/illness. This should include locations where exposure or stress occurred, as well as the number of hours per pay, per week of such exposure or stress.
- d. Identify the body part affected. (If disability is due to a heart attack or condition, given complete details of all activities for one (1) week prior to the attack with particular attention to the last 24 hours.)

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e. A statement as to whether the employee ever suffered a similar condition. If so, provide full details of history, current condition and medical care received. Include the names and addresses of treating physicians.

NOTE: IF THE EMPLOYEE'S STATEMENT IS NOT INCLUDED WITH THE CA-2, AN EXPLANATION FOR THE DELAY MUST BE GIVEN.

BLOCK 17 The employee must submit medical evidence to cover the following areas:

- a. Dates of examination or treatment.
- b. History given to the physician by the employee.
- c. Detailed narrative of the physician's findings.
- d. Results of X-rays, laboratory tests, etc.
- e. Diagnosis
- f. Clinical treatment
- g. A narrative explanation of the physician's opinion whether the disease/illness was caused or aggravated by the employment. (If the medical reports and narrative do not explain the basis for the physician's determination, the claim is given very little chance of being adjudicated.)

NOTE: IF MEDICAL REPORT IS NOT SUBMITTED WITH THE CA-2, AN EXPLANATION, FOR THE DELAY, MUST BE GIVEN.

BLOCK 18 Employee's signature and date.

The supervisor is responsible for completing Blocks 19 thru 35.

BLOCK 19 Enter the name and address of the reporting agency. The Adjutant General, WI, ATTN: WING-HR-MT, PO Box 8111, Madison, WI 53708-8111. **The OWCP Agency Code will be completed by the OWCP Specialist in the HRO.**

BLOCK 20 Complete address of employee's duty station, including zip code.

BLOCK 21 Enter employee's regular scheduled work hours.

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BLOCK 22 Check regular scheduled work days.

BLOCK 23 Enter name and address of physician providing treatment for work related disease/illness.

BLOCK 24 Obtain date from medical reports submitted by employee. If reports are not available, enter "Undetermined".

BLOCK 25 Refer to the most current medical reports. If reports are unavailable, enter "Unknown".

BLOCK 26 The specific date the supervisor was first notified of the disease/illness being related to Federal employment.

BLOCK 27 Time and date employee stopped work. If no disability occurred, enter **"Has not stopped"**.

BLOCK 28 Enter time and date employee's pay stopped (LWOP). If employee did not stop work, enter **"DID NOT STOP"**.

BLOCK 29 Based on the condition(s) identified as the cause of the disease/illness in the employee's statement, determine if a specific answer is possible.

BLOCK 30 Enter date and time the employee returned to work. If employee has not returned to work, enter "Has not returned".

BLOCK 31 If the employee's duties have been altered to meet medical restrictions (light duty), list the changes. If the employee can perform full duties, enter "N/A".

BLOCK 32 Enter employee's retirement coverage, CSRS, FERS or OTHER (specify)

BLOCK 33 If no evidence of a third party involvement for the disease/illness, check "NO". If there is evidence of a third party, check "YES" and enter the name and address of the third party in Block 34.

BLOCK 34 Enter third party's name and address if "YES" was checked in block 32.

BLOCK 35 Supervisor must sign, date, title and telephone number, including area code.

CHAPTER 4

NOTICE OF RECURRENCE OF DISABILITY AND CLAIM FOR CONTINUATION
PAY/COMPENSATION

4-1. Form CA-2a: Notice of Recurrence of Disability and Claim for Continuation of Pay/Continuation. This form is used to report a recurrence of an earlier disability (injury, disease/illness). Correct and accurate completion of the form is a MUST. The dates on

the CA-2a are extremely important, because they will be needed to establish entitlement for any unused COP.

4-2. Definition of a Recurrence. A recurrence is defined by OWCP as a spontaneous return or increase of disability due to a previous injury or occupational disease without a intervening cause. The supervisor must be aware that if an employee does something (lift, strain, fall or be exposed) to cause a medical condition to return or increase, as a result of a previous injury or disease, it is not a recurrence but a new injury or occupational disease claim.

NOTE: Because claims for recurrence are more complicated, the supervisor should contact the OWCP Specialist in the HRO for guidance.

4-3. Instructions on completing Form CA-2a. The employee, or person acting on the employee's behalf, must complete Blocks 1 thru 23.

BLOCK 1 Employee's last name, first name, middle name or initial (enter "NMN" for no middle name).

BLOCK 2 Employee's social security number.

BLOCK 3 The OWCP case (claim) number of the original injury or disease/illness.

BLOCK 4 Date of birth (month, day and year).

BLOCK 5 Sex.

BLOCK 6 Home telephone number (include area code), if no home telephone, enter "NONE".

BLOCK 7 The employee's complete home mailing address, include the zip code.

BLOCK 8 Check the appropriate box(es); however, if no dependents, "NONE" should be entered.

BLOCK 9 Employing office address (at the time of the original injury or disease/illness).

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BLOCK 10 Enter the name and address of employing agency only if different from Block 9.

BLOCK 11 Recurrence of a traumatic injury, use date in Block 10 on Form CA-1. If recurrence for occupational disease/illness, use date in Block 12 on form CA-2.

BLOCK 12 Enter date and time employee first became aware of the recurrence.

BLOCK 13 Enter date and time employee stopped work due to the recurrence. If employee did not stop work, enter "**Did not stop work**".

BLOCK 14 Enter date and time employee entered LWOP status otherwise **enter "N/A"**.

BLOCK 15 Enter date and time employee returned to work after recurrence. **Enter "N/A" if employee did not stop work**. Enter "Has Not Returned" if employee has not returned to work.

BLOCK 16 Enter date(s) when employee obtained medical treatment(s) for recurrence.

BLOCK 17 The name and address of treating physician.

BLOCK 18 If employee returns to work with no restrictions enter "No". If employee returns to work with work restrictions, enter "Yes" and list the restrictions.

BLOCK 19 A description of the medical condition should cover the entire period of time, include the improvement, condition worsening or remaining unchanged. List all medical treatment and prognosis of treatment for the period.

BLOCK 20 The description should cover where the condition recurred, what type activities were done, if any, when condition recurred. Give reasons why present condition is related to the original injury or disease/illness.

BLOCK 21 List all injuries and/or illness after the original date of injury and before the recurrence, occurring on or off the job and are not related to the original injury or disease/illness. Medical reports for the injuries and/or illness listed must be submitted.

BLOCK 22 Employee's signature.

BLOCK 23 Date employee signed form.

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The Supervisor is responsible for completing Blocks 24 thru 44.

BLOCK 24 Enter agency's name, address and include zip code.

BLOCK 24a The OWCP Agency Code will be completed by the OWCP Specialist in the HRO.

BLOCK 25 Enter employee's duty station, address and zip code.

BLOCK 26 Date the employee returned to work from the original injury or illness. (This date should be the same as Block 26 on CA-1, Block 30 on CA-2, or Block 10 on Form CA-3, Report of Termination of Disability and/or Payment.

BLOCK 27 Enter regular work schedule of the employee.

BLOCK 28 Check regular work schedule of employee.

BLOCK 29 Enter date of original injury or illness. This date is the same as Block 10 on CA-1, or Block 12 on CA-2.

BLOCK 30 Enter date employee first became aware of the recurrence. This date is the same as Blocks 12 and 20 of this form (CA-2a).

BLOCK 31 Enter date employee returned to work following recurrence.

BLOCK 32 Enter date when employee enters LWOP status; otherwise, enter "Has Not".

BLOCK 33 As result of recurrence, employee may be entitled to use the balance of his/her Continuation of Pay (COP). The recurrence must be within 45 days after the first return to work date. For clarification, please call the OWCP Specialist in the HRO or refer to the explanation contained in Chapter 2, Block 15 of this handbook. If the CA-2a is forwarded to OWCP before the employee returned to work, enter "Has Not Returned".

BLOCK 34 Enter "N/A" if employee has not stopped work. Enter date and time when employee returned to work following the period of recurrence. If the employee has not returned, enter "Has Not Returned".

BLOCK 35 If employee elects Annual and/or Sick Leave, either in lieu of COP or compensation for loss of wages, the beginning and ending dates of leave used is

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entered in appropriated box(es). NOTE: Employee must be in LWOP status before he/she can file for loss of wages.

BLOCK 36 Enter appropriate pay data. IMPORTANT: Loss of National Guard pay is compensable and should be computed for one (1) year prior, then enter in block 36d.

BLOCK 37 Check "YES" if employee received medical treatment at a unit clinic and submit medical reports. Check "NO" if employee did not receive medical treatment.

BLOCK 38 IMPORTANT: The Supervisor may issue Form CA-16, at his/her own discretion, provided the original claim has not been denied by OWCP or more than six (6) months has elapsed since the employee last returned to work, check "YES". Check "NO" if the CA-16 was not issued.

BLOCK 39 If employee was in or still is in light duty status, as a result of the original injury or illness, check "YES" and list accommodations. (If Duty Status Report, Form CA-17, was completed, use the work restriction listed to complete this section.) If employee was never placed on light duty and returned to full duty, check "NO".

BLOCK 40 Supervisor must review Part A of this form for completeness and for corrections. If the supervisor feels additional information is necessary, he/she should make the comments in this section.

BLOCK 41 Supervisor's signature.

BLOCK 42 Supervisor's title.

BLOCK 43 Supervisor's telephone number to include area code.

BLOCK 44 Enter date signed by the supervisor.

NOTE: Part C of this form, Blocks 1 thru 8, are to be completed only when the person is no longer a Federal employee. If this section needs to be completed, please call the OWCP Specialist in the HRO.

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CHAPTER 5

CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

5-1. Form CA-5: Claim for Compensation by Widow, Widower, and/or Children. The Form CA-5 is used by the Office of Workers' Compensation Programs to determine entitlements and all information **MUST BE ACCURATE**.

5-2. Responsibility. The supervisor must be aware that OWCP will not make compensation payments to an employee's spouse or next of kin until this form is

received in the OWCP office. If the supervisor has any questions, he/she should contact the OWCP Specialist in the HRO.

5-3. Instructions on Completing Form CA-5. The employee, or person(s) acting on their behalf, must complete Blocks 1 thru 19.

BLOCK 1 Employees last name, first name and middle name (enter "NMN" for no middle name.).

BLOCK 2 Employee's date of birth.

BLOCK 3 Enter date of injury. Employee's social security number.

BLOCK 4 Enter date of death.

BLOCK 5 Employee's social security number.

BLOCK 6 Enter name and address of employing agency (include zip).

BLOCK 7 Enter nature on injury which caused death.

BLOCK 8 thru 13 should be filled in by Surviving Husband, Wife or Children

BLOCK 8 Enter the name and address of surviving husband or wife.

BLOCK 9 Enter surviving husband or wife date of birth.

BLOCK 10 Enter date of marriage to employee.

BLOCK 11 Self explanatory.

BLOCK 12 Self explanatory.

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BLOCK 13 Self explanatory.

BLOCK 14 List all employee's children from this marriage who may be entitled to compensation (see next page)

BLOCK 14a List all employee's children from prior marriage who may be entitled to compensation (see next page)

BLOCK 15 If a legal guardian has been appointed for any child above, give name of child, name and address of guardian.

BLOCK 16 List other relatives who were fully or partially dependent on employee.

BLOCK 17 If application has been made for any Federal Retirement or Disability Law because of the employee's death, check appropriate box and the give appropriate information.

BLOCK 18 If application has been made for Veterans Administration (VA) benefits because of employee's death, fill in appropriate information.

BLOCK 19 IF a claim has been made against a third party because of employee's death, enter appropriate amount and give name and address of third party.

BLOCK 20 Enter total burial expense.

BLOCK 21 Enter amount of burial expense paid or payable by Veterans Administration (VA).

BLOCK 22 Enter name and address of party (other than VA) whose funds were used to pay burial expense and amount paid.

BLOCK 23 Person who is filing claim signs in this block.

BLOCK 24 Enter address, include zip code.

BLOCK 25 Enter date.

ATTENDING PHYSICIANS REPORT

Blocks 1 thru 13 should all be filled out by Attending Physician.

OFFICIAL SUPERIOR'S REPORT OF EMPLOYEE'S DEATH

6-1. Form CA-6: Official Superior's Report of Employee's Death. The Form CA-6 is used by the Office of Workers' Compensation Programs to determine entitlements and all information **MUST BE ACCURATE**.

6-2. Responsibility. The supervisor is responsible for filling out this form. The supervisor should supply a Form CA-5 to employee's spouse or next of kin. If the supervisor has any questions, he/she should contact the OWCP Specialist in the HRO.

6-3. Instructions on Completing Form CA-6. The supervisor must complete blocks 1 thru 36. If the supervisor has problems filling out the form, he or she should contact the OWCP Specialist in the HRO.

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CHAPTER 7

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY OR OCCUPATIONAL DISEASE

7-1. Form CA-7: Claim for Compensation on Account of Traumatic Injury or Occupational Disease. The Form CA-7 is used by the Office of Workers' Compensation Programs to determine entitlements and all information **MUST BE ACCURATE.**

7-2. Responsibility. The supervisor must be aware that OWCP will not make compensation payments to an employee until this form is received in the OWCP office. The employee must be in a LWOP status to receive compensation for loss of wages.

The CA-7 form should be filed five (5) days prior to termination of COP. If the supervisor has any questions, he/she should contact the OWCP Specialist in the HRO.

7-3. Instructions on Completing Form CA-7. The employee, or person(s) acting on their behalf, must complete Blocks 1 thru 19.

BLOCK 1 Employees last name, first name and middle name (enter "NMN" for no middle name.)

BLOCK 2 The OWCP case (claim) number from original injury.

BLOCK 3 Employee's social security number.

BLOCK 4 Enter the beginning and ending dates of the lost time due to the injury and the number of hours. IMPORTANT: If an employee is filing for a Scheduled Award, enter "N/A".

BLOCK 5 Check "YES" if claim is for a scheduled award and "NO" if not.

BLOCK 6 If employee received pay (sick and/or annual leave) for the period in Block 4, check "YES" and complete Block 7. If the employee did not receive pay in Block 4, check "NO" and enter "N/A" in Block 7.

BLOCK 7 Enter the dollar amount of pay for period claimed in Block 4, also enter the beginning and ending dates for that period.

BLOCK 8 Complete this item if you worked during the period shown in Item 6. Attach a separate sheet if needed.

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BLOCK 9 If there was no third party claim, check "NO" and enter "N/A" in Blocks 9 and 10. If the supervisor feels that a third party was involved in the claim, he/she should contact the OWCP Specialist in the HRO for guidance.

BLOCK 10 Enter the name and address of the person or the insurance company responsible as the third party.

BLOCK 11 If a monetary settlement has been received by the employee from the third party, enter the amount of the settlement in this block. Enter "NONE" if no settlement was paid.

BLOCK 12 Check appropriate box. If "YES" provide the information as requested in a, b, and c.

BLOCK 13 Check appropriate box. If "YES" provide the information as requested in a, b, and c.

BLOCK 14 List all relatives (including adopted children) who are dependent on the employee for support (a spouse living with an employee is considered a dependent, whether or not he/she is financially dependent on the employee).

BLOCK 15 If the employee is not making support payments, check "NO" and enter "N/A" in Blocks 16, 17 and 18. If the answer is "YES", and the employee is making support payments, complete Blocks 16, 17 and 18, and attach a copy of the court order to the CA-7. Check "NO" if not.

BLOCK 17 Enter name and address of the person receiving the support payments.

BLOCK 18 Enter the dollar amount of support being paid.

BLOCK 19 Employee's signature and date. (Be sure the employee reads the statement in Block 18 before signing form.)

BLOCK 20 Employee's home mailing address, including zip code.

BLOCK 21 Enter pay rate on the date of injury and enter pay rate at the time the employee stopped work in block 21a. Blocks 21b and 21c, for all practical purposes, will not be used. Block 20d will be used to enter lost National Guard military pay. Enter the amount of military pay received for one year prior to the date of injury. (Military pay is included as part of the compensation pay rate because military membership in the National Guard is a mandatory requirement for civilian employment.)

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BLOCK 22 If employee is receiving Premium Pay, Sunday Pay or Night Pay, check appropriate box and enter the amount of pay received. The section "Other" is used if employee is being paid Environmental Differential Pay or Hazardous Duty Pay(EDP/HDP). If the employee is being paid other pay, check "Other", identify type of pay and enter the amount of pay received. This pay is to be computed for all pay earned one (1) year prior to date of injury. (ATTENTION SUPERVISOR: Do not enter any "overtime" pay in the block "Other". Under compensation law, overtime pay will not be considered part of the compensation pay rate.)

BLOCK 23 Check the appropriate blocks for the days of employee's regular work week when employee's pay stopped and employee was put in a LWOP status.

BLOCK 24 Check the appropriate box.

BLOCK 25 Check the appropriate box. (**Check the "NO" box only if a temporary employee.**)

BLOCK 26 Include all Federal Civil Service.

BLOCK 27 If the employee has no health insurance, check "NO". If the employee has health insurance, check "YES" and enter the health insurance enrollment code in appropriate boxes. Enter the pay period ending date on which the payroll office made deductions for health insurance. NOTE: IF the supervisor does not know the information for health insurance, he/she would contact the OWCP Specialist in the HRO, for assistance.

BLOCK 28 If the employee has Basic Life Insurance, but no Optional Life Insurance check "NO". If the employee has Optional Life Insurance, check "YES" and complete the remainder of Block 26. The information to complete Block 27 is found on SF 2817, Life Insurance Election form. Block A is for Option A-Standard, Block B is for Option B-Additional and Block C is for Option C-Family. (Check the block(s) that corresponds with the most current SF 2817.) NOTE: If the supervisor does not have access to the needed information for Block 27, he/she should contact the OWCP Specialist in the HRO.

BLOCK 29 If the employee has used sick and/or annual leave since he/she stopped work, enter in the appropriate blocks the beginning and ending of each type of leave used including LWOP. IMPORTANT: do not enter Continuation of Pay (COP) in any of these blocks.

BLOCK 30 Enter the amount of COP used (beginning and ending date).

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BLOCK 31 Enter the date and time employee stopped work.

BLOCK 32 Enter the beginning and ending dates for the time lost due to injury. If the employee has not returned to work, enter "Unknown" in the ending date section. The supervisor should check Block 4, which was completed by the employee. The dates in Block 4 and Block 31 should be the same. NOTE: If the employee is filing for a scheduled award, enter "N/A".

BLOCK 33 Enter date and time the employee returned to work. If employee has not returned, enter "Has not returned".

BLOCK 34 Check the days of the work week that the employee returned to work. If the employee has returned, enter "N/A".

BLOCK 35 If employee has returned to full duty, check "NO". If the employee has returned, with work restrictions (light duty), check "YES" and list the changes of work assignment.

BLOCK 36 Enter the pay rate of the employee on the day the employee return to work.

BLOCK 37 Supervisor signs form and enters his/her title, date, address and telephone number.

BLOCK 38 Enter the OWCP Specialist's (in the HRO) name, and telephone number (include area code).

7-4. Attending Physician's Supplemental Report, Form CA-20. (See Chapter 11) This form can be obtained from the OWCP Specialist in the HRO Office. This form is to be completed by the treating physician. The physician is responsible for forwarding this form to the HRO office.

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CHAPTER 8

WHAT A FEDERAL EMPLOYEE SHOULD DO WHEN INJURED AT WORK

This should be posted in all facilities, on a bulletin board that is accessible to all employees.

CHAPTER 9

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT

9-1. CA-16: Authorization for Examination and/or Treatment. This form is used to authorize initial medical treatment in Traumatic Injury cases **ONLY**. The employee has the right to select his/her own physician, provided the physician is located within a 25 mile radius of the employee's residence or work station. The employee is NOT obligated to go to the agency's medical facility. **ATTENTION**: The employee should be advised that Chiropractors cannot be paid for any services other than "manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist".

9-2. Responsibility. The supervisor is responsible to authorize medical treatment, for the injured employee, upon notification of the injury. In case of an emergency, the CA-16 may be used up to 48 hours after the date of injury. Retroactive issuance of the CA-16 is not permitted. Only one (1) CA-16 may be completed per traumatic injury.

9-3. Instructions for Completing Form CA-16. The supervisor is responsible for completing PART A - AUTHORIZATION (Blocks 1 thru 13).

BLOCK 1 Enter the full name and complete address of the treating physician and/or health care facility. (If issued to cover emergency care after the fact, enter "Emergency care provided".) The supervisor should not issue CA-16 if 48 hours has elapsed since date of injury.

Form CA-16 should rarely be issued in cases of recurrence; however, if CA-16 is authorized, the same medical provider should be used to ensure the continuity of care.

The CA-16 may not be issued if more than six (6) months have elapsed since the employee last returned to work. The CA-16 may not be issued to authorize a change of physician after the initial choice has been exercised by the injured employee. Check with OWCP Specialist in the HRO before issuing CA-16 for recurrence.

BLOCK 2 Enter employees last name, first name and middle name (enter "NMN" for no middle name.)

BLOCK 3 Enter date of injury. See Block 10 on the CA-1.

BLOCK 4 Enter the employee's job title.

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BLOCK 5 Provide a description of the injury. This information can assist the treating physician.

BLOCK 6 Section 6A: Pertains to the treating physician. Section 6B: If there is no doubt as to the validity of the injury, check B-1. Check B-2 if there is a doubt that injury did not happen at the work site and the medical condition is not a result of an accident.

BLOCK 7 This Block is used only when authorization has been received from the Office of Workers' Compensation Programs (OWCP) to issue a Form CA-16 for Occupational Disease/Illness. When the CA-16 is issued, the supervisor must enter the name and title of the OWCP official that authorized treatment.

BLOCK 8 Supervisor's signature that authorized medical treatment.

BLOCK 9 Enter name and title of supervisor.

BLOCK 10 Enter the telephone number of the OWCP Specialist in the HRO.

BLOCK 11 Enter date the Form CA-16 was issued.

BLOCK 12 Enter the mailing address of servicing OWCP District Office (U.S. Dept. of Labor, OWCP, 230 South Dearborn Street, Eighth Floor, Chicago, IL 60604).

PART B: Attending Physician's Report. Blocks 14 thru 38 must be completed by the treating physician.

NOTE: Any time the CA 16 is issued, payment is guaranteed even if Block 6 (b-2) is checked and/or the claim is denied.

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CHAPTER 10

DUTY STATUS REPORT

10-1. CA-17. Duty Status Report. This form is to be used by the supervisor and/or HRO at any time the employee is absent from work due to a traumatic injury and/or disease/illness. This form is to request information from the treating physician on whether the injured employee may return to work. The information provided on this form will allow the supervisor (and/or HRO) to determine if work restrictions are involved and to determine what light duty position or modified position are needed for the employee to return to work.

10-2. Use of Form CA-17. The CA-17 is used during the COP period or LWOP status. This form should be issued every two (2) weeks (attach a copy of the position description when forwarded to the physician the first time). The CA-17 can be issued more frequently if there is some doubt as to the extent of the disability.

10-3. Instructions on Completing Form CA-17. The supervisor completes Blocks 1 thru 7t.

BLOCK 1 Enter the name and address of the treating physician or medical facility.

BLOCK 2 Enter the OWCP file/claim number.

BLOCK 3 Enter the employee's last name, first name and middle name (enter "NMN" for no middle name).

BLOCK 4 Enter the employee's job title, date of the original injury (See block 10 on the CA-1) or if an occupational disease/illness, enter date found in Block 12 of the Form CA-2.

BLOCK 5 Supervisor must describe how the injury/illness occurred and what body parts were affected. (Refer to Blocks 13 and 14 on the CA-1 for an injured employee or Block 14 on the CA-2 is claim if for occupational disease/illness.

BLOCK 6 Enter the number of hours per day, per week worked.

BLOCKS 7a-t The supervisor should check the appropriate boxes to advise the treating physician of the actual physical requirements/duties of the employee's position.

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BLOCKS 8 thru 20 Are to be complete by the treating physician. NOTE: When this form is mailed to the treating physician, be sure to give a suspense date or ask them to return as soon as possible.

MEDICAL FACILITY NAME AND ADDRESS: Enter the name of the clinic/hospital/urgent care facility and address.

SEND ORIGINAL REPORT TO: Human Resources Office, ATTN: WING-HR-MT, PO Box 8111, Madison, WI 53708-8111

SEND A COPY OF THIS REPORT TO: Leave this blank. The OWCP Specialist in the HRO will send a copy to the Office of Workers' Compensation Programs

CHAPTER 11

ATTENDING PHYSICIAN'S REPORT

Attending Physician's Report. This form must be completed by the attending or treating physician. The physician is responsible for forwarding this form to the OWCP Specialist in the HRO Office. The OWCP Specialist, in turn, will forward the completed CA-20 to OWCP.

CHAPTER 12

CLAIMANT MEDICAL REIMBURSEMENT FORM

CA-915. This form is used when an employee pays for prescription medicine or medical supplies (i.e., knee brace, crutches, canes, wheel chair, etc.) All receipts must accompany the CA-915 and should be forwarded to the OWCP Specialist in the HRO Office. The OWCP Specialist, in turn, will forward the completed CA-915 to OWCP. Be sure employee signs and dates CA-915.

CHAPTER 13**HEALTH INSURANCE CLAIM FORM**

13-1. HCFA 1500/OWCP 1500: Health Insurance Claim. This form is used to request payment for all medical bills (except hospital bills). Medical bills submitted to OWCP that are not on this form will not be paid and will be returned; however, OWCP will forward a letter, with the returned bills, explaining how to properly submit billings to OWCP district office. This form does NOT replace a medical report nor can it be used as a form "request for surgery authorization". Medical support is required to substantiate that services for which payment or reimbursement is requested were required. Documentation usually takes the form of a report or clinical notes from the physician. Hospital bills should be supported by a copy of the discharge summary.

13-2. Responsibility of Completing Form HCFA 1500/OWCP 1500. It is the employee's and treating physician's responsibility to complete each section of this form. The supervisor is not responsible for completion; however, the supervisor should have extra forms available for the employee to hand carry to the treating physician or medical facility. For bills to be considered for payment, bills must be submitted to OWCP within a year after the end of the calendar year in which the expense was incurred or 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.

13-3. Instructions on Completing Form HCFA 1500/OWCP 1500. The employee or person(s) acting on the employee's behalf are responsible for completing Blocks 1 thru 13.

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CHAPTER 14

OWCP MEMORANDUM (WIARNG Form 250-R)

14-1. WIARNG Form 250-R: OWCP Memorandum on "Technician's Rights and Responsibilities for a Work Related Injury", should be completed by the technician for each traumatic (CA-1) or occupational (CA-2) claim.

14-2. The technician should read the form and complete item #1-d (Attending Physician's name, address, and phone number) and item #7 (Authorization to Release Medical Records). This form can be reproduced locally.

CHAPTER 15**OCCUPATIONAL DISEASE CHECKLISTS**

15-1. The Federal Employees' Compensation program has developed eight checklists to assist employees and agency personnel in gathering and submitting material for adjudication of occupational disease claims. The forms, which are illustrated on the following pages are:

<u>Form No.</u>	<u>Condition Addressed</u>
CA-35a	Occupational Disease in General
CA-35b	Hearing Loss
CA-35c	Asbestos-Related Illness
CA-35d	Coronary/Vascular Disease
CA-35e	Skin Disease
CA-35f	Pulmonary Illness (not Asbestosis)
CA-35g	Psychiatric Illness
CA-35h	Carpal Tunnel Syndrome

