Ground Floor, Federal Building, 215 Bay Street, Jacksonville, Florida, 32205 while at work, in performance of my duties.

While inspecting a piece of luggage coming through the conveyor belt, picked up a very large overweight and heavy suitcase, weighing about 100 pounds or more, felt pop in back and fell to floor in excruciating pain.

Strained lower back area, both legs and left elbow while trying to break fall to the floor.

While inspecting a piece of luggage coming through the conveyor belt, picked up a very large overweight and heavy suitcase, weighing about 100 pounds or more, felt pop in back and fell to floor in excruciating pain.

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*3 year Time Limitation*

If no witness, N/A

If witnessed, SIGNATURE AND STATEMENT REQUIRED.
Official Supervisor's Report: Please complete information requested below:

<table>
<thead>
<tr>
<th>SS Chargeback Code</th>
<th>DWCP Agency Code</th>
<th>OSHA Site Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0000LV SSS</td>
<td></td>
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</tbody>
</table>

Dept of ENERGY

Federal Building, 215 Bay Street, Jacksonville, Florida 32205

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

Employee's retirement coverage

Regular work hours:
- From: 0600 a.m.
- To: 1700 p.m.

Regular work schedule:
- Sun: Off
- Mon: On
- Tues: Off
- Wed: Off
- Thurs: Off
- Fri: Off
- Sat: Off

Date of injury:
- Mo: 3
- Day: 17
- Yr: 03

Date notice received:
- Mo: 3
- Day: 17
- Yr: 03

Date pay stopped:
- NA

Date 45 day period began:
- Mo: 3
- Day: 18
- Yr: 03

COP HRS/W/E HOLIDAYS

Date returned to work:
- Mo: 3
- Day: 17
- Yr: 03

DISABLED

Date received medical care:
- Mo: 3
- Day: 17
- Yr: 03

First date medical care received:
- Mo: 3
- Day: 17
- Yr: 03

Medical reports show employee is disabled for work:
- Yes

Name and address of physician first providing medical care:
- Dr. J. Bird
- 500 Bay Meadows Rd.
- Jacksonville, Florida 32205
- (999) 000-0000

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

Date of injury does not agree with statement of the employee and/or witnesses:
- Yes

Disability continued for work:
- Yes

U. R. Right

Within 7 days to OWCP from Date of Injury: 3-17-03

Signature of supervisor:

Form CA-1.
Rev. Apr. 1999
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 re-continuation of pay (COP) from your employing agency. COP paid for up to 45 calendar days of disability, and is not chargeable 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.

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 legally 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.

35) If the employing agency contests continuation of pay, state the reason in detail.
COP may be contested (disputed) for any reason, however the employing agency may refuse to pay COP only if the controversy 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 the employee was not involved in official “off premise” duty;
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.

Employmen 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.

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 can be obtained from your personnel or compensation office, or contacting OWCP.
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 anyone acting on his/her behalf must file the 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.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such period, 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 leg, 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 necessary medical care from qualified medical providers.

An employee may use sick or annual leave rather than LWCP while disabled. The employee’s employer may purchase leave used for approved periods. Form CA-7b, available from the personnel office, should be submitted 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. 8701, 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 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. (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.

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

(TO EMPLOYEE FROM SUPERVISOR)

This acknowledges receipt of Notice of Injury sustained by

Jane E. Doe

This notice of injury.

3-17-03

At (Location) Federal Building, 215 Bay Street, Jacksonville, Florida

Signature of Official Superior

U. R. Right

Title Supervisor, Inspection

Date (Mo. Day, Yr.) 3-17-03

(WEIIN 4 HRS OF INJURY) Form CA-1 Revised Apr. 1999

*U. S. Gov. 1999-34084-12784