TRAUMATIC INJURY RESOURCE GUIDE & CONTINUATION OF PAY(COP)

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The CA-1

Was your injury due to a *specific event*?

What to do when you have a traumatic injury

A traumatic injury is defined as:

"A wound or other condition of the body caused by external force, including stress or strain, which is identifiable as to the time and place of occurrence and member or function of the body affected. The injury must be caused by a specific event or incident or series of events or incidents within a single workday or work shift."

The key to this definition is that an event or events must have occurred during a single workday or work shift.

STEP 1: NOTIFYING YOUR SUPERVISOR

Immediately notify your supervisor and request:

Form CA.-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (must be supplied immediately)

Form CA-16, Authorization for Examination and/or Treatment (must be supplied by your manager within 4 hours)

Form CA-17, Duty Status Report (must be supplied immediately)

Forms CA-1 and CA-17 are available at the Department of Labor website

STEP 2: THE CA-1

If you do not need immediate medical attention, fill out the CA-1 . The burden of proof in every OWCP case rests on the injured worker; you must be an active participant in the claims process. Be thorough in describing the accident and related factors.

Fill out the CA-1 yourself – do not let a supervisor fill it out for you! At the bottom of the CA-1, question number 15 allows you to choose either Continuation of Pay (COP) or Sick leave. If you elect COP you will be paid your regular pay for 45 calendar days.

For the first three days of COP, you must use either sick leave, annual leave or leave without pay. After that, you will continue to get paid every two weeks as if you were working. if your absence exceeds 14 days, ask the Postal Service to convert your first 3 days to COP and credit the proper leave account. You must supply medical evidence of your injury, signed by a doctor within 10 days to qualify for COP.

Once you have reviewed and signed your CA-1, physically hand the completed CA-1 to your supervisor. Do not leave it on your supervisor's desk or inbox. Request that your supervisor gives you the signed receipt (page 4) immediately. Once you are certain that the CA-1 has been properly completed, request a copy for your file.

The CA-1 receipt establishes a record of your injury and the date you filed your claim.

The Postal Service has 10 working days to submit the CA-1 to the Office of Worker's Compensation Programs, (OWCP). Once management has completed their portion of the CA-1, get a copy of it for your files. Build a file of every document related to your injury, including medical reports and documents from the Postal Service and OWCP.

STEP 3: SEEKING MEDICAL TREATMENT

Form CA-16 authorizes payment for medical treatment and provides an initial medical report. Make sure the Postal Service properly fills out their portion of the CA-16, signing and dating it and putting OWCP's address in Box 12. The CA-16 is a payment voucher for medical treatment for on the job injuries. You can use the CA-16 to see the doctor of your choice. Make sure to get a copy of the CA-16 from your medical provider after they fill it out completely. Provide a copy of the CA-16 to your immediate supervisor.

You have the right to seek treatment from your own doctor. If the Postal Service insists that you go to their doctor, you must be seen by them, but you do not have to be treated by them. Seek guidance from your steward or the branch on seeking an opinion from a second physician. The second visit establishes your physician of choice and cannot be changed without approval from DOL.

If you are examined by a physician's assistant or nurse practitioner, your medical report must be counter-signed by a doctor.

Provide the doctor with a copy of the CA-17. The Postal Service is responsible for filling out the job requirements on the left (side A) of the CA-17. Your doctor fills out the right (side B) of the CA-17, listing any medical restrictions. Make a copy of the completed CA-17 and give one copy to your supervisor.

The Postal Service has 10 business days to send your claim to OWCP. OWCP will send you a notification including your claim number. If you do not receive a notice from OWCP with your claim number contact your shop steward or Branch office.

Your medical records are protected by the Privacy Act. Your Postmaster, manager and supervisor are not entitled to your personal medical records. OWCP is responsible for the protection of all your medical records.

Step 4: Contact your shop steward for further guidance

It is important that you keep your shop steward or the Branch in the loop about the injury. If you miss time from work due to the injury the FECA provides that management must pay COP for the first 45 days. Furthermore, it is our goal to point you in the right direction so that your claim gets approved and there is no delay in payment of COP. Also, here are additional steps that you might need to take if you disability goes beyond the initial 45 days.

Step 5: Continuing treatment/returning to work

Follow your doctor's restrictions. Delivering mail is physically demanding work, and returning to work before you have healed can lead to life-long debilitating injuries. Take a CA-17 to every medical appointment and provide a copy to your supervisor.

The Postal Service has an obligation to offer you work within your restrictions. The completed CA-17 must be provided to the Postal Service to determine if there is work available within your restrictions. If the Postal Service offers you work and you are uncertain if you can do it, you have the right to request a written job offer to take to your doctor.

Medical reports should be sent directly to OWCP, **NOT THE POSTAL SERVICE**. Your doctor may send the reports directly to OWCP or you can upload them into your file via ECOMP.

Step 5: Managing your claim

Once you have filed your claim, OWCP has three options:

1. Request more information

OWCP will notify you if your case lacks enough information to make a decision in your case. They will send you a development letter requesting more information listing a series of questions for both you and your doctor to answer. These letters always give you exactly 30 days from the date on the letter to respond.

It is important that you act quickly to get the questions answered within the 30-day time limit. Make an appointment with your doctor as soon as possible. Bring the OWCP letter to your appointment. and ask your doctor to thoroughly answer the questions. OWCP must receive the information within the 30 days, a postmark is insufficient. Make sure your doctor understands the urgency. Use ECOMP to upload your documents directly to your file if necessary.

Never forward documents without first making copies for your own records. You need to organize your records to be ready to respond to OWCP. If you have problems with your claim, contact a branch officer or National Business Agent to find an NALC representative to assist you. FECA gives you the right to appoint a representative of your choice.

2. Claim acceptance

In accepting your claim, OWCP has determined the documentation provided was sufficient. If you are on COP and it appears you will not return to work after 45 days, the Postal. Service is required to provide you with form CA-7 to request wage-loss compensation after 30 days. The CA-7 comes with instructions on how to properly fill it out and submit it.

If you do not receive a CA-7 from the Postal Service, request one from your supervisor or print one from the DOL's website. Submit the completed CA-7 every two weeks, usually on the last Friday, to your district Health Resource Management, HRM office. Send a written request for a copy of the completed CA-7, including management's portion, for your file every time you submit it to HRM.

Ask your supervisor for the HRM office's address and fax number. The Postal Service has five working days to complete their portion of the CA-7 and send it to OWCP. Always keep a copy of your CA-7 for your file.

If the Postal Service notifies you that they have a Limited Duty Job Offer (LDJO) for you, you need to examine it and see if it falls within your doctor's restrictions listed on your most recent CA-17. If the job offer looks reasonable and is within your medical restrictions, accept the job offer and begin working it. If you think the job offer exceeds those limitations, you have the right to take the job offer to your doctor and let the doctor determine if the job offer is within your medical restrictions.

Never refuse a job offer. If management demands you accept or reject a job offer, accept the offer and write "pending doctor's approval" next to your signature. FECA regulations and the ELM allow you to have your doctor review any job offer for compliance with your medical restrictions.

You should take the job offer to your doctor as soon as possible and give a copy of the response to the Postal Service and OWCP. The Postal Service may make multiple job offers and you should follow the procedures above every time.

OWCP has the sole authority to determine whether the job offer is suitable. If OWCP determines that the job offer is suitable, it is required to notify the employee in writing and give the employee 30 days to begin the job.

3. Claim Denial

If OWCP denies your claim, they will normally list the reason(s) why. Along with the denial, OWCP will give you a list of your appeal rights. Each venue has specific time limits that are absolute. In order to successfully appeal the denial, you must address OWCP’s reason(s) for the denial. It often involves further medical documentation and new medical opinions from your doctor or specialist. Contact a branch officer to solicit help in choosing a proper venue for appeal.

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

Reset Print

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

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

Employee Data

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

Description of Injury

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

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

Employee Signature

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

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

☐ b. Sick and/or Annual Leave

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

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

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

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

Witness Statement

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

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

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

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.

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

Authorization for Examination And/Or Treatment

U.S. Department of Labor
Office of Workers' Compensation Programs

The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. 130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. NOTE: THIS FORM IS NOT TO BE REPRODUCED OR DUPLICATED (See Instructions). IF INSTRUCTIONS ARE SEPARATED FROM THIS FORM, REFER TO FORM INFORMATION https://www.dol/owcp/dfec

OMB No.: 1240-0046
Expires: 03-31-2021

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service within the meaning of FECA (See Instructions for definition of a qualified physician):

2. Employee's Identification (last, first, middle, SSN)	3. Date of Injury (mo. day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services. PLEASE NOTE THIS AUTHORIZATION DOES NOT INCLUDE PRESCRIPTIONS FOR COMPOUND MEDICATIONS. SEE INSTRUCTIONS FOR ADDITIONAL MEDICAL INFORMATION.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from (Type Name and Title of OWCP Official)

8. Name and Address of Employee's Place of Employment

Department or Agency:

Bureau or Office:

Local Address (Including Zip Code)

9. Local Employing Agency Telephone Number (Including Area Code):

10. Name and Title of Authorized Official (Type or Print Clearly): (See Instructions)

11. Send one copy of your report to:

U.S. DEPARTMENT OF LABOR
DFEC CENTRAL MAILROOM
P.O. BOX 8300
LONDON, KY 40742-8300

12. I certify that I am the individual authorized by my employing agency to issue this form concerning medical treatment. I further certify that the information provided above is true and accurate to the best of my knowledge and belief. I realize that any person who knowingly makes any false statement or misrepresentation to obtain FECA compensation is subject to civil or administrative remedies as well as criminal prosecution.

Signature of Authorizing Official/Date (Month, Day/Year)

13. Remarks (See Instructions under Authorized Official):

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

15. What History of the Employment Injury or Disease Did The Employee Give To You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. ICD Code(s)

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is the Diagnosed Condition(s)

18a. ICD Code(s)

19. Do You believe the Condition(s) Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) ☐ Yes ☐ No

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee Is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. 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.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. I certify that all the statements in this form are true and accurate to the best of my knowledge and belief. Further, I understand that 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, including payment for medical treatment or supplies, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both, and that physicians are subject to criminal and civil prosecution. In addition, a state or federal criminal conviction for FECA fraud will result in a beneficiary's termination of all current and future FECA benefits.

Print/Typed Name/Signature of Physician (See Instructions for Definition)

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

PAYMENT/MEDICAL BILLING: This CA-16 guarantees payment to the original treating physician (or any physician to whom the employee was referred by the original treating physician) for 60 days from date of issuance unless OWCP terminates this authority at an earlier date. Treatment may continue at OWCP expense if the claim is approved. Charges for your services should be presented on the AMA standard "Health Insurance Claim Form" (HCFA-1500, OWCP-1500, OWCP-04 or the UB-04). Physician services must be itemized by Current Procedural Terminology Code (CPT) using current CPT-4 coding schema; or, the UB-04 and the coding schemas acceptable on this form.

Injured Carrier Checklist

_____ _____
Name of Carrier Date of Injury

Was the Injury caused by a specific event _____ _____
(If yes complete CA-1 follow instructions below) Yes No

Step 1 – Report Injury

Immediately report Injury to Supervisor _____
Name of Supervisor and date reported

Request the following forms:

CA-1 (Report of Injury must be supplied immediately) _____

A CA-16 signed by management (Authorization for Treatment must be supplied within 4 hours) _____

CA-17 (Duty Status Report must be supplied immediately w/ left side completed) _____

Step 2 - Paperwork

Fill out CA-1 yourself (if immediate medical attention is not needed) _____

Request COP or S/L (if COP is requested the first 3 days must be sick or annual leave) **IF YOU REQUEST & DONT GET PAID COP CONTACT YOUR STEWARD - FILE A GRIEVANCE!!!!!!** _____

Sign & and give completed CA-1 to Supervisor and get receipt on page 4 of CA-1 _____

Step 3 – Seek Medical Attention

Bring CA-16 & CA-17 with you to your medical appointment _____

If you are seen by a PA (physician's assistant or CNP (Nurse Practitioner) all medical reports must be countersigned by MD _____

Have your medical provider complete right side of CA-17 _____

Initial Medical Report must be provided within 10 days _____

Follow the restrictions of your Doctor

Step 4 – Dealing with OWCP

Receive Claim number from OWCP within 21 days (if not contact the Branch or Regional Office) _____

OWCP Request's for more information – You have 30 days to submit the information requested. _____

Acceptance letter – When your case is accepted, the letter will identify those conditions that are accepted along with proper coding (payment for other conditions may be denied) _____

Denial Letter – Contact the Branch or Regional Office to discuss your appeal rights as some options have different time limits _____