

Federal Workers' Compensation: Filling Out the Forms (CA-1)

Questions 1-12

General Data

General information such as name, address and date of birth.

Question 13

Cause of Injury

Go into detail on how the injury occurred and everywhere you felt pain initially or subsequently. If extra space is needed attach a typed explanation.

Question 14

Nature of Injury

List all body parts that initially or later were painful. A non-painful body part now may have a silent injury that will reappear later and need treatment or an impairment rating. It is very helpful to submit medical records with your CA-1 form. If attaching records write, "Attached are medical records: 1) ABC Emergency Room, 1/1/2017, 2) Marcus Welby, MD, 1/4/2017.

Question 15

Payment if Off Work

Usually select 15 a. COP continuation of regular pay. If off for more than 45 days you will be put on OWCP workers' compensation payments at 75% of your regular pay with dependents or 66.6% without dependents. Payments are income tax free.

Question 16

Witness Statement

It is helpful if you can obtain witness statements. They can be on separate pages.

Form CA-1, Page 2

Supervisor's Report

This page is to be filled out by your supervisor.

Form CA-1, Page 3

Instructions

This is the instructions for filling out Form CA-1.

Form CA-1, Page 4

Receipt of Notice Injury

Make a copy of your form CA-1, witness statements and medical records. Give the original form CA-1 and records to your supervisor. Have your supervisor sign your copy.

Your supervisor is required to send your form CA-1, witness statements and medical records to OWCP within 10 days. If your supervisor delays, then you send your form CA-1 and records to OWCP.



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

How do you wish to file?

Online: www.ecomp.dol.gov

Paper: dol.gov/sites/dolgov/files/owcp/regs/compliance/ca-1.pdf

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)			1a. Email address		2. Social Security Number	
3. Date of birth Mo. Day Yr.		4. Gender	5. Home telephone		6. Grade as of date of injury Level Step	
7. Employee's home mailing address (include street address, city, state, and ZIP code)					8. Dependents	
City State ZIP Code					<input type="checkbox"/> Wife, Husband	
					<input type="checkbox"/> Children under 18 years	
					<input type="checkbox"/> 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.
			12. Employee's occupation

13. Cause of injury (Describe what happened and why)

**Go into detail about how the injury occurred.
If you need more space, attach a typed explanation.**

14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg)

LIST ALL BODY PARTS! It is very difficult to add an effected body part after the process has begun, so it is very important to include any and all effected body parts that are or were painful. Medical records are extremely helpful, especially if the physician provides medical rationale.

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 **Usually Select 15. ☐ a. Continuation of regular pay (COP)**

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 Worker's Compensation Program (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 this 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)

Very helpful, a witness statement attached to your CA- I, can make the difference between a claim being excepted or denied.

Name of witness		Date signed	
Address City State ZIP Code			

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.

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include street address, city, state, and ZIP code)		OWCP Agency Code
<div>How are you going to file? Online: OWCP will send your CA-1 to your supervisor to complete this section. Paper: Give to your supervisor, be sure to have them sign the Receipt of Notice of Injury (the last page of this form) they will then send the completed form to OWCP within 10 days.</div>		OSHA Site Code
City		State

18. Employee's duty station (include street address, city, state and ZIP code)	City	State	ZIP Code
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19. Employee's retirement coverage	<input type="checkbox"/> CSRS	<input type="checkbox"/> FERS	<input type="checkbox"/> Other, (identify)
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20. Regular work hours	From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule	<input type="checkbox"/> Sun.	<input type="checkbox"/> Mon.	<input type="checkbox"/> Tues.	<input type="checkbox"/> Wed.	<input type="checkbox"/> Thurs.	<input type="checkbox"/> Fri.	<input type="checkbox"/> Sat.
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22. Date of Injury	23. Date notice received	24. Date stopped work	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	

25. Date pay stopped	26. Date 45 day period began	27. Date returned to work	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.	

28. Was employee injured in performance of duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain)
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29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?	<input type="checkbox"/> Yes (If "Yes," explain) <input type="checkbox"/> No
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30. Was injury caused by third party?	31. Name and address of third party (include street address, city, state, and ZIP code)
<input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to Item 32.)	City
	State
	ZIP Code

32. Name and address of physician first providing medical care (include street address, city, state, ZIP code)	33. First date medical care received	Mo. Day Yr.
City	State	ZIP Code
	34. Do medical reports show employee is disabled for work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain)
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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	<input type="checkbox"/> No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
	<input type="checkbox"/> No lost time, medical expense incurred or expected: forward this form to OWCP
	<input type="checkbox"/> Lost time covered by leave, LWOP, or COP: forward this form to OWCP
	<input type="checkbox"/> 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)

1a) Email address

Injured workers should provide an email address when completing this form. Pursuant to policy established by the Department of Labor, Office of Workers' Compensation Programs (OWCP), Division of Federal Employees' Compensation, email communication on case specific inquiries is not allowed due to security concerns. However, obtaining claimant email addresses at the point of filing will allow OWCP to share general, non-case specific information with injured workers earlier in the claims submission process. As a longstanding policy and in an effort to protect the identities and personal information of claimants under the Federal Employees' Compensation Act, and to allow better tracking of incoming communications, we do not use two-way email as a primary method of interaction with claimants and their representatives.)

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

As 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 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 continues 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 deformation 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

Which occurred on (Mo. Day, Yr.)

At (Location)

Signature of Official Superior

How do you intend to file?**Online:** Upload all medical records to OWCP in PDF format.**OWCP will contact your employer to obtain your wage information.****Paper:** Supervisors are required to send Form CA-1 and any medical records to OWCP**within 10 days. If your supervisor delays sending in your CA-1 and medical records, then you will need to send the Form CA-1 and medical records directly to OWCP yourself.****Submit online:** www.ecomp.dol.gov**Submit by fax:** 202-343-5570**Submit by mail:**

**U.S. Department of Labor
Office of Workers' Comp Programs
P.O. Box 8300
London, KY 40742-8300**

Date (Mo. Day, Yr.)