

Federal Workers' Compensation: Filling Out the Forms (CA-2)

Questions 1-8

General Data

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

Question 9

Employee Occupation

Attach a list of your employment and work activities that contributed to your conditions.

Question 11

Date of Awareness

The date you began to hurt or have problems.

Question 12

Date You First Realized the Disease or Illness was Caused or Aggravated by Your Employment

This date is important because it sets your pay rate if off work and the rate of impairment compensation. Since OWCP requires a physician's well-reasoned medical rationale as to how and why employment factors caused, aggravated or contributed to an employee's condition, the Date You Realized can be the date a physician told you that your condition was related to your employment.

Question 13

Explain the relationship to Your Employment, and Why you Came to this Realization

The best method is to attach a physician's medical report with their well-reasoned medical rationale. In #14, write "See attached D. Marcus Welby, 10/1/2013 medical report". If the medical records are not attached with your Form CA-2, the Claims Examiner will not have enough information to accept the claim.

Question 14

Nature of Disease or Illness

The best method is to attach a physician's medical report with their well-reasoned medical rationale. In #14, write "See attached D. Marcus Welby, 10/1/2013 medical report".

Question 15

If Notice Was Filed More than 30 Days from Date Realized

Supply your reasons such as, "I was not able to obtain my medical records until the day I filed my Form CA-2".

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Questions 16

Employee Statement & Medical Report Regarding Employment Factors Causing Your Condition

See last page for Instructions for Completing Form CA-2 for what is needed in your Employee Statement. You must submit a physician's opinion as to whether the disease or illness was caused or aggravated by the employment.

Question 17

Medical Records

Form CA-2 requires medical records and must have a physician's opinion as to whether the disease or illness was caused or aggravated by the employment.

Form CA-2, Page 2

Supervisor's Report

This page is to be filled out by your supervisor.

Form CA-2, Page 3

Receipt of Notice Injury

Make a copy of your form CA-2, witness statements and medical records. Give the original form CA-2 and records to your supervisor.

Have your supervisor sign your copy.

Your supervisor is required to send your form CA-2, witness statements and medical records to OWCP within 10 days. If your supervisor delays, then you send your form CA-2 and records directly to OWCP. If you are no longer working for the employer where you were injured then you send Form CA-2 directly to OWCP.

Form CA-2, Page 4

Instructions

This is the instructions for filling out Form CA-2.

Notice of Occupational Disease and Claim for Compensation

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



Employee: Please complete all boxes 1 - 18 below. Do not
Employing Agency (Supervisor or Compensation Specialist):

Electronic filing: www.ecomp.dol.gov
If your agency does not accept electronic claims, then file on paper.
Paper filing: www.dol.gov/owcp/regs/compliance/ca-2.pdf

Employee Data

1. Name of Employee (Last, First, Middle)					2. Social Security Number	
3. Date of birth	Mo.	Day	Yr.	4. Sex	5. Home telephone	6. Grade as of date of last exposure
					()	Level Step
7. Employee's home mailing address (include street address, city, state, and ZIP code)						8. Dependents
City						<input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other
State						ZIP Code

Claim Information

9. Employee Occupation: Attach a list of your employment and work activities that contributed to your conditions.		a. Occupation code
10. Location where you worked when disease or illness occurred (include street address, city, state, and ZIP code)		11. Date of Awareness: The date you began to hurt or have problems.
City		
State		ZIP Code

12. Date You Realized Condition Was Caused or Aggravated by Your Employment:
This date is important because it sets your pay rate if off work and the rate of impairment compensation. Since OWCP requires a physician's well reasoned medical rationale as to how and why employment factors caused, aggravated or contributed to an employee's condition, the Date You Realized can be the date a physician told you that your condition was related to your employment.

13. Explain Relationship of Employment and Why You Came to this Realization:
The best method is to attach a physician's medical report with their well reasoned medical rationale. In #14, write "See attached D. Marcus Welby, 10/1/2013 medical report". If the medical records are not attached with your Form CA-2, the Claims Examiner will not have enough information to accept the claim.

14. Nature of Disease or Illness: The best method is to attach a physician's medical report with their well reasoned medical rationale. In #14, write "See attached D. Marcus Welby, 10/1/2013 medical report".

15. If Notice Was Filed More than 30 Days from Date Realized: Supply your reasons such as, "I was not able to obtain my medical records until the day I filed my Form CA-2."

16. Employee Statement & Medical Report Regarding Employment Factors Causing Your Condition. See last page for Instructions for Completing Form CA-2 for what is needed in your Employee Statement. You must submit a physician's opinion as to whether the disease or illness was caused or aggravated by the employment.

17. Medical Records: Form CA-2 requires medical records and must have a physician's opinion as to whether the disease or illness was caused or aggravated by the employment.

Employee Signature

18. Receipt of Notice of Occupational Disease or Illness:
Make a copy of your Form CA-2, witness statements and medical records. Give your Form CA-2 and records to your supervisor. Have your supervisor sign your copy. Your supervisor is required to send your Form CA-2, witness statements and medical records to OWCP within 10 days. If your supervisor delays, then you should send your Form CA-2 and records directly to OWCP. If you are no longer working for the employer where you were injured then you send Form CA-2 directly to OWCP.

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

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

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.

Official Supervisor's Report of Occupational Disease: Please complete information requested below**Supervisor's Report**

19. Agency name and address of reporting office (include street address, city, state, and ZIP Code)		OWCP Agency Code -
		OSHA Site Code
City	State	ZIP Code
20. Employee's duty station (include street address, city, state, and ZIP code)		City
		State
		ZIP Code
21. 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.	22. 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.
23. Name and address of physician first providing medical care (include city, state, ZIP code)		24. First date medical care received
		Mo. Day Yr
		25. Do medical reports show employee is disabled for work?
City		State
ZIP Code		<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Date employee first reported condition to supervisor	Mo. Day Yr.	27. Date and hour employee stopped work
Mo. Day Yr.	Mo. Day Yr.	Time
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
28. Date and hour employee's pay stopped		29. Date employee was last exposed to conditions alleged to have caused disease or illness
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.
Time	Time	Time
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
30. Date returned to work		
Mo. Day Yr.		
Time		
<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party?

☐ Yes ☐ No
If "No," go to Item 34.

34. Name and address of third party (include street address, city, state, and ZIP code)

City State ZIP Code

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to 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

Disability 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 general benefits for employment-related occupational disease or illness:

- (1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.
- (2) Payment of compensation for total or partial wage loss.
- (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 disfigurement of the head, face, or neck.
- (4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

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.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

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 Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

INSTRUCTIONS FOR COMPLETING FORM CA-2

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. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the Employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

- a) A detailed history of the disease or illness from the date it started.
- b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.
- c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.
- d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)
- e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

- a) Dates of examination or treatment.
- b) History given to the physician by the employee.
- c) Detailed description of the physician's findings.
- d) Results of x-rays, laboratory tests, etc.
- e) Diagnosis.
- f) Clinical course of treatment.
- g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible 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 must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

- a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.
- b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.
- c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.
- d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)
- e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanation: Some of the items on the form which may require further clarification are explained below.**14. Nature of the disease or illness**

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. 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).

23. 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.

24. First date medical care received

The date of the first visit to the physician listed in item 23.

32. Employee's Retirement Coverage.

Indicate which retirement system the employee is covered under.

33. Was the 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 disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes**Box a (Occupational 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, Record Keeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit 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.