

Federal Workers' Compensation: Filling Out the Form (CA-2a) Notice of Recurrence

Form CA-2a, Page 1

Form CA-2a Notice of Recurrence

Sometimes Form CA-2a can be difficult to get accepted. If still working, it is may easier to file a new claim with a Form CA-2. A new claim date will usually result in a higher pay and/or impairment rate.

When to Use

When to use a Form CA-2a

If your injury claim is closed, then worsens and you need treatment. Claims are automatically closed if OWCP does not receive physician correspondence every 180 days. Claims can be reopened if there is a physician's medical rationale.

If, after retiring, you have consequential injuries or conditions. If your accepted condition causes consequential injury use Form CA-2a. Examples: Bad knees and limp causing back injuries. Carpal tunnel surgery causing ligament tightening the elbow causing Cubital tunnel syndrome of the ulnar nerve. If still working it is usually best to file and new claim with Form CA-2.

You are again losing wages or you are off work due to your injury. You will need to attach a Form CA-2a to a Form CA-7. Make sure you place a checkmark in Box C of Section 2 on Form CA-7, labeled "Other wage loss".

Form CA-2a, Page 2

Federal Employing Agency Report

This page is to be filled out by your supervisor.

Form CA-2a, Page 3

Form CA-2a Employee's Work History Since Date of Injury

This is to be filled out only if you did not work for the Federal Government at the time of the recurrence.

Form CA-2a, Page 4

Instructions

This is the instructions for completing Form CA-2a Notice of Recurrence.

Form CA-2a, Page 5

Accommodation Statement

This describes your right to receive assistance from OWCP with regards to the claims process if your disability hinders your capability to file your claims forms etcetera.



Employee: Complete Part A below.

Employing Agency (Supervisor or Compensation

Note: Persons are not required to respond to this collection of information unless it displays a currently

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-2a.pdf****Part A - Employee**

1. Name of employee (Last, First, Middle) [Redacted]		2. Social Security Number [Redacted]	3. OWCP file number for original injury [Redacted]	
4. Date of birth Mo. Day Yr. [Redacted]	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Home telephone [Redacted]		
7. Home mailing address (include street address, city, state, and ZIP code) [Redacted] City State ZIP Code [Redacted]			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	
9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code) [Redacted]		10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also. [Redacted]		
11. Date and Hour of original injury (mo., day, year) [Redacted]	12. Date and Hour of recurrence (mo., day, year) [Redacted]	13. Date and Hour stopped work after recurrence (mo., day, year) [Redacted]	14. Date and Hour pay stopped after recurrence (mo., day, year) [Redacted]	15. Date and Hour returned to work (mo., day, year) [Redacted]
<input type="checkbox"/> Medical Treatment Only <input type="checkbox"/> Time Loss From Work		17. Date of first medical treatment following recurrence (mo., day, year) [Redacted]	18. Name and address of treating physician [Redacted]	

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) ☐ Yes ☐ No
Go into detail describing exactly how your injury has effected your ability to perform any functions associated with your employment. Be sure to list every aspect of your job that has been adversely effected. If this limitation is no longer effecting your employment be sure to state how long you were limited, otherwise mention the condition is ongoing.

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.

[Redacted]

21. Describe how and when the recurrence happened. Explain how your current condition is related to the original injury.
If you have aggravated an old injury it is sometimes easier to file a new Form CA-2 for occupational disease instead of a CA-2a. Form CA-2a is best used if you now longer are working for the government. If no longer working send your Form CA-2a and medial records to OWCP and then OWCP will contact your agency to complete their section.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.
It is usually best that your Form CA-2a have an attached medical opinion report, that fully provides the medical rationale of how your worsened or consequential conditions are related to your employment factors.

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 Federal Employees' Compensation Act (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.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

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.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee	24. Date (mo., day, year)
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Part B - Federal Employing Agency

25. Name and address of reporting office (include street address, city, state, and ZIP Code)				OWCP Agency Code	
City				State	
ZIP Code				OSHA Site Code	
26. Employee's duty station (include street address, city, state, and ZIP Code)				27. Date of first return to FULL- TIME REGULAR duty following original injury	
				Mo. Day Yr.	
City				State	
ZIP Code					
28. 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.				29. Regular work days <input type="checkbox"/> Sun. <input type="checkbox"/> Tues. <input type="checkbox"/> Thurs. <input type="checkbox"/> Mon. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.	
30. Date of injury Mo. Day Yr.		31. Date of recurrence Mo. Day Yr.		32. Date stopped work after recurrence Mo. Day Yr.	
				Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
33. Date pay stopped after recurrence Mo. Day Yr.		34. Dates COP paid for recurrence From Mo. Day Yr. To Mo. Day Yr.		35. Date returned to work after recurrence Mo. Day Yr.	
				Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
36. Did the employee receive medical care at an agency facility due to the recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please attach all relevant medical records.				37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? <input type="checkbox"/> Yes <input type="checkbox"/> No	
38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, provide full details.					
39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.					
40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.					
A supervisor or compensation specialist 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.					
41. Signature of Supervisor or Compensation Specialist (at time of recurrence)		42. Title		43. Work phone	
				44. Date (mo., day, year)	

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

\$ per

5. Do you claim compensation for lost wages? ☐ Yes ☐ No

If so, for what period? through

6. Have you received any pay during the period claimed? ☐ Yes ☐ No

If so, how much and from what source?

NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 to the U.S. Code. Furnishing the requested information is required to obtain and retain benefits in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee

8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a

NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work-related injury. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the now incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment; history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. **The physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original injury.** Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations:
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless: the claimant is still receiving continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting ~~neither wage-loss compensation nor payment of medical expenses~~. In these instances, file the form in the Employee Medical Folder.
- If COP is being paid, obtain medical evidence using Form CA-17, "Duty Status Report", as often as circumstances indicate.
- For a recurrence less than 90 days after the employee's return to work following the original injury, you may authorize required medical care using Form CA-16. For a recurrence more than 90 days after the employee's return to work, OWCP must authorize further medical care.
- For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.
