UNITED STATES POSTAL SERVICE™

Injury Compensation

Handbook EL-505 December 1995

Transmittal Letter

1. **Explanation.** Handbook EL-505 is a reference for injury compensation control office and control point personnel at postal facilities to manage the USPS Injury Compensation Program.

2. **Distribution**

   Initial. Handbook EL-505 is distributed to area injury compensation offices. Further distribution to the postal facilities will be accomplished by the area Human Resources injury compensation analyst.

   Additional Copies. Additional copies will be maintained by the area Human Resources injury compensation analyst.

3. **Comments**

   Submit questions and suggestions about the content of this document in writing to:

   OFFICE OF SAFETY AND RISK MANAGEMENT
   US POSTAL SERVICE
   475 L'ENFANT PLAZA SW RM 9801
   WASHINGTON DC 20260-4232

   Submit questions regarding the organization or editing of this document to:

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   INFORMATION SYSTEMS
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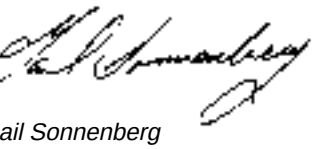
4. **Cancellations.** The previous issue of Handbook EL-505 is obsolete.

5. **Effective Date.** This handbook is effective December 1995.



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Vice President
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Introduction

Purpose of the Handbook

Handbook EL-505, *Injury Compensation*, is a comprehensive guide to help injury compensation control office (ICCO) and designated control point personnel perform their jobs.

In this handbook, we have attempted to compile and update all applicable U.S. Postal Service (USPS) regulations, policies, and guidelines into one user-friendly manual. The handbook serves as both a training tool and a reference guide. It covers many injury compensation (IC) issues, including:

— The history of the USPS Injury Compensation Program.

— Certain provisions of the Federal Employees' Compensation Act (FECA).

— Staffing and supplying an ICCO.

— Responses to employee injuries.

— Claims management.

— Records management.

— Limited duty and rehabilitation.

— Legal issues surrounding injury compensation.

Using this handbook alone is not sufficient for the effective management of a USPS Injury Compensation Program. A complete list of supplementary IC resource materials is, therefore, included in Chapter 1.

Finally, it is important to note that while responsible parties and means of implementation may vary from one installation to another, the USPS responsibilities and obligations set forth in the boxed portions of this guide and labeled "Obligation" are mandatory.

How to Use the Handbook

The Text

This handbook comprises 13 chapters, each beginning with a brief overview of the topics covered. Chapter 1 is considered a reference chapter and should be used to answer fundamental questions concerning workers' compensation. When a chapter is written for personnel in a specified Postal Service position, the relevant position is indicated.

Each chapter is separated into sections that refer to various situations you may encounter through the normal routine of your job. Each situation is followed by one or more responses you may make, then by specific tasks. The following is an example of what you will see:

Claims Management in Case of Death ← Here is a situation.

When the ICCO receives notice of a death from a traumatic injury or potentially from an occupational disease or illness...

14.4 Contacting the Employee's Family — *supervisor or ICCO* ← This is one of the responses which is...

□ Contact the employee's family, and do the following:

— Offer assistance in completing the appropriate claim form....

— Ensure that the employee's family is advised of their rights under FECA....

— Explain to the employee's family the distinction between OPM and OWCP benefits....

← composed of several tasks.

□ If the investigation reveals a basis to challenge the claim, prepare a challenge package in accordance with Chapter 8, Controversion and Challenge, and submit this to OWCP along with CA-5 or CA-5b.

◇ *Ensure that family contact is conducted in accordance with the local installation's established protocol.* ← This is a cautionary note.

Sections showing obligations that result from the law or from USPS policy are framed with solid lines and labeled "Obligation" as follows:

Obligation: Assigning Limited Duty

When an employee is not totally disabled or has partially overcome the injury or disability, the USPS must make every effort to assign the employee to limited duty consistent with the employee's work limitation tolerance.

Sections that provide information that will help you fulfill the tasks outlined are framed with dotted lines, for example:

Assigning an Employee to Limited Duty

When an employee has partially overcome the injury or disability, the USPS must make every effort toward assigning the employee to limited duty consistent with the employee's work limitation tolerance.

The Appendixes

Throughout the handbook, you will find references to appendixes. You will find these appendixes at the end of the handbook. They are labeled as follows:

— Appendix A, Abbreviations and Acronyms.

— Appendix B, Addresses.

— Appendix C, Definitions.

— Appendix D, Forms.

1. USPS Injury Compensation Program

Overview

Background Information

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- Purpose of FECA
- Family and Medical Leave Act
- Privacy Act

Eligibility

General Provisions of FECA

- Employee Entitlements
  - Continuation of Regular Pay
  - Compensation for Wage Loss
  - Medical Care
  - Vocational Rehabilitation
  - Schedule Awards
  - Compensation for Loss of Wage-Earning Capacity
  - Death Benefits
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- Third Party Liability
- Appeal Rights
- Withdrawal of a Claim
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  - Penalty for False Statement
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Relevant Provision of FMLA

Responsibilities

- Office of Workers' Compensation Programs, U.S. Department of Labor
- U.S. Postal Service
  - Headquarters

- Area Offices
- Districts and Plants
- Control Offices
- Installations

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Resource Materials

Regulations, Policies, and Procedures

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1. The USPS Injury Compensation Program

Overview

This chapter provides basic information about the USPS Injury Compensation Program. It first highlights the history and various provisions of the Federal Employees' Compensation Act (FECA). Then it describes the organization and staff responsibilities. The last part of the chapter lists valuable resource material to include in your injury compensation (IC) office.

Background Information

History

The USPS Injury Compensation Program was established in 1978 after the USPS realized it needed to establish a program to deal with the escalating costs of workers' compensation benefits. It is important to understand the history of FECA and the relationship between the USPS Injury Compensation Program and the Office of Workers' Compensation Programs (OWCP).

In 1908, President Theodore Roosevelt signed legislation to provide workers' compensation for certain federal employees in unusually hazardous jobs. The scope of the law was very restricted, and its benefits were quite limited. However, it was the first workers' compensation law to pass the constitutionality test of the U.S. Supreme Court.

The Federal Employees Compensation Act (FECA), enacted in 1916, is a workers' compensation law for civilian federal employees. Originally it included wage loss compensation, medical care, and survivors' benefits provisions. An independent quasi-judicial Employees' Compensation Commission administered the law.

Administrative responsibility for FECA was assigned to the Department of Labor (DOL) in 1950. FECA is now administered by the Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor.

In 1974, FECA was amended, increasing benefits and significantly changing the law by adding provisions such as continuation of pay (COP) and claimant's choice of physician. The effect of this amendment eventually led to the establishment of the USPS Injury Compensation Program.

Purpose of the Federal Employees' Compensation Act

FECA provides compensation benefits to civilian employees of the United States for disability because of personal injury or disease sustained while in the performance of duty. FECA also provides for the payment of benefits to

dependents if a work-related injury or disease causes an employee's death. FECA is intended to be remedial in nature, and proceedings under it are nonadversarial.

Family and Medical Leave Act

Provisions of the Family and Medical Leave Act (FMLA) cover some absences for job-related injuries or illnesses that also qualify as serious health conditions.

Privacy Act

Injury compensation records are maintained by the USPS within the privacy system of records identified as USPS 120.098 (OWCP Record Copies) and 120.099 (Injury Compensation Payment Validation Records).

Eligibility

Under the provisions of the Postal Reorganization Act, 39 U.S.C. 1005(c), all employees of the USPS are covered by FECA. This coverage extends to all full-time, part-time, and temporary (including casual and transitional) employees, regardless of the length of time on the job or the type of position held. (*Federal (FECA) Procedure Manual* (FECA PM) 2-802)

General Provisions of the Federal Employees' Compensation Act

Employee Entitlements

Continuation of Regular Pay

An employee's regular pay may be continued for up to 45 calendar days of wage loss because of disability and medical treatment following a traumatic injury. This is to ensure that the employee's income is not interrupted while the claim is being adjudicated. COP is not considered compensation and is therefore subject to income tax, retirement, and other deductions. After entitlement to COP is exhausted, the employee may apply for compensation or use leave. (20 CFR 10.200; FECA PM 2-807)

SEE Chapter 4, Claims Management.
Chapter 13, Timekeeping and Accounting.

Compensation for Wage Loss

OWCP establishes the employee's pay rate for compensation purposes based on one of the following:

— Pay rate on date of injury.

— Date disability began.

— Date disability recurs if it is more than 6 months after the employee returns to full-time employment.

In cases of total disability, an employee is entitled to compensation at the rate of 66 2/3 percent of the employee's established pay if there are no dependents, or 75 percent of the pay if there are one or more dependents. Pay may include additional amounts that may be included in salary, such as premium pay, night and Sunday differential, and cost-of-living allowance.

Compensation payments for total disability may continue as long as the disability continues, which may mean the lifetime of the employee. There is no total dollar maximum. (20 CFR 10.300 through 303; FECA PM 2-900)

Medical Care

If the claim is accepted as compensable under FECA, the injured employee is entitled to medical services. These include examinations, treatments, and related services such as hospitalization, medications, appliances, supplies, and transportation, as prescribed or recommended by qualified physicians that in the opinion of OWCP are likely to cure, give relief, or reduce the degree or the period of disability (see Appendix C, Definitions, for *physician*). However, preventive care may not be authorized. There is no dollar maximum or time limitation on medical care. It will be provided as long as the evidence indicates it is needed for the effects of the injury. (20 CFR Subparts E and F; FECA PM 2-810 and Part 3, Medical Management, FECA PM)

SEE Chapter 4, Claims Management.
Chapter 6, Medical Management.

Vocational Rehabilitation

Rehabilitation services may be arranged to assist in training for work that the claimant can perform if the injured employee suffers a job-related handicap because of the injury and cannot resume usual employment. Rehabilitation service is supervised by OWCP but is usually provided in cooperation with state or private rehabilitation agencies. When rehabilitation is under way, OWCP may provide a monthly maintenance allowance not to exceed $200 in addition to compensation for wage loss. (20 CFR 10.124; FECA PM 2-813; OWCP PM)

SEE Chapter 11, Rehabilitation Program.

Schedule Awards

Compensation is provided for permanent loss or loss of use (either partial or total) of certain internal organs, members, or functions of the body such as arms, legs, hands, feet, fingers, toes, or eyes and loss of hearing or loss of vision.

Schedule awards may be paid for different body parts.

Each extremity has been rated for a specific number of weeks of compensation. If a serious disfigurement of the head, face, or neck results from a job-related injury, an award may also be made for such disfigurement. Schedule awards may be paid concurrently with Office of Personnel Management's (OPM) retirement benefits.

Schedule awards can be paid even if the employee returns to work or is no longer under actual medical care. Employees may not, however, receive wage loss compensation and schedule award benefits concurrently for the same injury. If an employee sustains a period of temporary total disability during the course of the award, the award may be interrupted to pay for the period of disability. The schedule award resumes after the employee returns to work. If an employee dies during the course of a schedule award from causes unrelated to the compensable injury, his or her dependents are entitled to the balance of the award at the rate of 66 2/3 percent of the employee's established pay. (20 CFR 10.304; FECA PM 2-808)

Compensation for Loss of Wage-Earning Capacity

When an injured person suffers a wage loss because of a disability that is less than total, compensation may be paid for loss of wages or wage-earning capacity (LWEC). The injury compensation control office (ICCO) may request that an LWEC determination be made by the OWCP claims examiner if sufficient medical evidence indicates that an individual who is receiving compensation has attained maximum medical improvement, is unable to return to the position held at the time of injury (or to earn equivalent wages), and is not totally disabled for all gainful employment. If the employee is reemployed at a job paying less than the original position, or if it is determined that he or she can perform the duties of a specific job that is deemed suitable by OWCP, compensation will be payable based on the LWEC determination. (20 CFR 10.303; FECA PM 2-813)

SEE Chapter 11, Rehabilitation Program.

Death Benefits

In the event of death because of employment, FECA provides up to $800 for funeral and burial expenses.

If the employee dies away from his or her place of residence, the cost of transporting the body to the place of burial is paid in full. In addition, a $200 allowance is paid for administrative costs of terminating a decedent's employee status with the federal government.

Survivors are entitled to benefits in the form of compensation payments:

— A surviving spouse with no eligible children is entitled to compensation at the rate of 50 percent of the deceased employee's salary.

— Benefits are paid to the spouse until death or remarriage before age 55. If a spouse under age 55 remarries, OWCP makes a lump-sum payment equal to 24 times the monthly compensation at the time of remarriage. The benefits of a spouse who remarries after the age of 55 are not affected by the marriage.

— If children are eligible in addition to the spouse, the spouse may receive compensation equal to 45 percent of the employee's regular pay, plus an additional 15 percent for each child, to a maximum of 75 percent of the deceased employee's regular pay. The children's portion is paid on a share and share alike basis. Eligible children include:

  - An unmarried child under the age of 18, or over the age of 18 who is incapable of self-support because of mental or physical disability.
  - A child between 18 and 23 years of age who has not completed 4 years of post high school education and is regularly pursuing a full-time course of study.

— If the deceased employee leaves no spouse, the first child is entitled to 40 percent and each additional child is entitled to 15 percent of the employee's salary up to a maximum of 75 percent, payable on a share and share alike basis.

Other surviving dependents may be entitled to compensation benefits at various percentages according to degree of dependence. Monthly payments for all beneficiaries cannot exceed 75 percent of the employee's monthly pay rate or 75 percent of the top step of a GS-15 salary, whichever is less. Other persons who may qualify are dependent parents, brothers, sisters, grandparents, and grandchildren. However, the surviving spouse and children have first priority. (20 CFR 10.306 and .307; FECA PM 2-700; Publication CA-810, *Injury Compensation for Federal Employees*)

SEE Chapter 4, Claims Management.

Attendant Allowance

Employees who are injured so severely that they are unable to meet their own physical needs such as feeding, bathing, or dressing may qualify to receive an attendant's allowance up to a maximum of $1,500 per month. This allowance may be paid in addition to compensation for wage loss. (20 CFR 10.305, FECA PM 2-807, Publication CA-810, Chapter 7, Compensation Benefits)

Cost-of-Living Adjustments

Compensation benefits are increased by the applicable consumer price index effective March 1 each year for all beneficiaries who have been in receipt of benefits for more than 1 year prior to that date.

Dual Benefits

FECA prohibits payment of compensation and certain other federal benefits at the same time.

— *Office of Personnel Management (OPM)*. Except for schedule awards, a person may not receive disability benefits from OWCP concurrently with a regular or disability annuity (either Civil Service Retirement System (CSRS) or Federal Employees' Retirement System (FERS)) nor may a person receive death benefits from OWCP concurrently with a survivor's annuity (either CSRS or FERS). Therefore, a beneficiary who is entitled to both benefits must elect between them.

— *Department of Veterans Affairs (VA)*. Beneficiaries who receive compensation from the VA may also be required to elect between the benefits paid by that agency and those paid by OWCP. An election is required between VA and

FECA benefits if a VA award is increased because of the compensation injury. The election is only between the increase and FECA benefits.

— *Social Security Administration (SSA).* An employee or the employee's survivor may receive Social Security payments payable on account of nonfederal employment and OWCP benefits at the same time, subject to income limitations imposed by the SSA. For FERS employees, any portion of SSA old age retirement or death benefits attributable to an employee's federal service is deducted from compensation payable.

— *Other Federal Income.* An employee or the employee's survivor may receive compensation concurrently with military retired pay, retirement pay, retainer pay, or equivalent pay for service in the armed forces or other uniformed services subject to reduction of such pay in accordance with 5 U.S.C. 5532 (b).

An employee may receive severance pay concurrently with compensation for a schedule award or for loss of wage-earning capacity but not with compensation for temporary total disability.

Finally, an employee may receive unemployment compensation benefits concurrently with OWCP benefits.

Third Party Liability

In instances in which an employee's injury or death in the performance of duty occurs under circumstances creating a legal liability on some person or party other than the U.S. government, the employee (or survivor in the case of death) is encouraged to pursue a third party claim.

An employee who refuses to pursue recovery from a liable third party after being asked to do so by the DOL may be denied compensation. The USPS may assist in obtaining a settlement. An employee who sustains a job-related injury cannot recover damages from the United States for the effects of the injury except through FECA. (20 CFR Subpart G; FECA PM 2-1100)

SEE Chapter 10, Third Party Liability.

Appeal Rights

If an employee or the survivors disagree with the final determination made by OWCP, a hearing may be requested to give the claimant an opportunity to present evidence in further support of the claim or ask that the claim be reconsidered by the OWCP district office. Also, there is a provision for additional review by OWCP and a right to appeal to the Employees' Compensation Appeals Board (ECAB), a separate entity of DOL. Three avenues of appeal are provided for employees; the USPS is not entitled to appeal. Only one type of appeal may be requested by the employee at a time. The types of appeal include:

— *Hearing.* The employee is entitled to either an oral hearing before an office representative or a review of the written record (but not both) as long as the request is made within 30 days of the formal decision and reconsideration

has not already been requested. The employee may change his or her hearing request in writing within 30 days of OWCP's acknowledgment of the initial request.

— *Reconsideration*. The employee may request OWCP to reconsider a formal decision made by the district office. The request should clearly and concisely state the ground on which it is based and should be substantiated by relevant evidence not previously submitted. A reconsideration must be requested within 1 year of the date the contested formal decision was issued.

— *Employees' Compensation Appeals Board (ECAB) Review.* The employee may request review by ECAB, the highest authority in FECA claims. ECAB's review is based solely upon the case record at the time of the formal decision. New evidence is not considered by ECAB. Employees residing within the U.S. or Canada have 90 days from the date of decision to file for review. Employees residing outside the U.S. or Canada must file within 180 days of the date of decision. For good cause shown, ECAB may waive a failure to file an application within 90 days or 180 days, but no more than one year from the date of the final decision. (20 CFR 10.133 through 139; FECA PM 2-1600 through1603)

SEE Chapter 8, Controversion and Challenge.

Withdrawal of a Claim

All employees' claim forms (CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, and CA-2, *Notice of Occupational Disease and Claim for Compensation)* are official records of the OWCP and not the USPS. (20 CFR 10.10)

Employees who desire to withdraw a claim on these or any other official OWCP forms should be referred to OWCP.

Penalties

Penalty for False Statement

Any employee, supervisor, or representative who knowingly makes a false statement with respect to a claim under FECA may be subject to a fine of not more than $10,000 or 5 years in prison, or both. (20 CFR 10.23)

Penalty for False Claim

Any employee, supervisor, or representative who, with respect to a claim under FECA, enters into any agreement to obtain the payment or allowance of any false or fraudulent claim may be subject to a fine of not more than $10,000 or 10 years in prison, or both. (20 CFR 10.23)

Penalty for Refusal to Process Claim

Any employee or supervisor responsible for making reports in connection with an injury who willfully fails, neglects, or refuses to do so; induces, compels, or directs an injured employee to forego filing a claim; or willfully retains any notice, report, or paper required in connection with an injury may be subject to a fine of not more than $500 or 1 year in prison, or both. (20 CFR 10.23)

Penalty for Fraudulently Claiming or Obtaining Benefits

Claimants convicted of fraudulently claiming or obtaining benefits under FECA cited in Public Law 103-333, effective 9/30/94, lose entitlement to medical benefits, compensation for wage loss, and any other benefits payable under FECA. (20 CFR 10.23)

Pending Disciplinary Action

USPS administrative disciplinary action must not be delayed based on current claim status.

Relevant Provision of FMLA

An employee may be on a workers' compensation absence because of a job-related injury or illness that also qualifies as a serious health condition under FMLA. The workers' compensation absence and FMLA leave may run concurrently (subject to proper notice and designation by the employer). At some point the health care provider providing medical care pursuant to the workers' compensation injury may certify the employee is able to return to work in a limited duty position. If the employer offers such a position, and the employee does not accept the position, the employee may no longer qualify for workers' compensation benefits, but the employee is entitled to continue on unpaid FMLA leave either until the employee is able to return to the same or equivalent job the employee left or until the 12-week FMLA leave entitlement is exhausted.

Responsibilities

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

OWCP has the exclusive authority (except as otherwise provided by law) for the administration, implementation, and enforcement of FECA. Its main responsibility is to determine whether the claimant is entitled to benefits under FECA. Claim decisions, determinations, and adjudications are made in the name of, or for, the director of OWCP.

Responsibility for FECA is vested in 12 OWCP district offices. The locations and jurisdiction of these offices are identified in Appendix B, Addresses.

U.S. Postal Service

Headquarters

The manager of Safety and Risk Management:

— Establishes policy and procedures through the vice president of Human Resources (HR).

— Coordinates and provides technical guidance in field activities to ensure uniform management of the program.

— Identifies training needs for those involved in administering the program.

— Coordinates efforts with DOL in conjunction with the USPS responsibilities under FECA.

— Provides reports to postal management at all levels about the status of the program.

— Identifies program initiatives to enhance effective program management.

Area Offices

Area HR managers:

— Implement the national Injury Compensation Program policies and directives.

— Oversee areawide program activities to ensure compliance with national policies and guidelines.

Area HR analysts for injury compensation:

— Advise Headquarters on the status of the Injury Compensation Program within the area and assist in the administration of policy, programs, and procedures that affect the program.

— Provide technical assistance and guidance to Customer Services and Sales (CSS) districts and Processing and Distribution (P&D) centers, satellite offices, and their assigned ICCO personnel in relation to the program.

— Manage and oversee cost-reduction initiatives and case management techniques.

— Define area goals and objectives within the guidelines established by Headquarters.

Districts and Plants

Customer Service and Sales district HR managers:

— Implement Headquarters and area program policies, objectives, and action plans within the district boundaries.

— Ensure that authorized IC positions are staffed, sufficient ICCO staff (HR specialists) are assigned and trained (see pp. 2 through 4), and appropriate control point personnel are designated.

Managers of P&D centers, bulk mail centers (BMCs) and air mail centers:

— Implement the objectives and policies of the program within the operations under their jurisdiction.

— Ensure that control point personnel are designated, where appropriate.

Control Offices

ICCOs are physically located at district offices and selected satellite offices. They are supervised by a senior IC specialist and staffed by a designated number of HR specialists and, in some offices, HR associates.

Senior IC specialists:

— Oversee program administration within the district boundaries.

— Supervise ICCO activities.

— Assist management in the selection and designation of ICCO or control point personnel.

— Ensure that ICCO or control point personnel are properly trained.

ICCO personnel:

— Administer and control all aspects of the Injury Compensation Program within the domiciling installation and defined area of responsibility.

Installations

Control point personnel are designated by the installation head (or functional manager in large installations). At least one control point person must be designated for each tour of operation. Control points report functionally to either the senior IC specialist or to the designated ICCO in program matters.

Control point personnel (all management levels):

— Authorize medical treatment in accordance with CFR 10.402(a).

— Review medical documentation to determine employee's duty status.

— Coordinate activities of first-line supervisors relative to claims management efforts.

First-line supervisors:

— Perform claims management activities immediately following the injury.

— Investigate the circumstances surrounding the injury.

— Conduct all necessary coordination and follow up with designated control point supervisors and ICCOs.

Employees:

— Fulfill their obligations as set forth in this chapter.

Claims Administration Hierarchy

Claims administration responsibility always rests with the ICCO at a management level above that of the injured employee. Designated ICCO-employee relationships are as follows:

Employee	Control Level
Craft employees Supervisors Postmasters	District
District managers and direct manager reports Plant managers All full-time and collateral IC personnel	Area
Area managers Headquarters and Headquarters-related units (unless otherwise advised)	Headquarters

Resource Materials

Regulations, Policies, and Procedures

This handbook is a compilation of various USPS-issued regulations, policies, and procedures. However, because of the nature and complexity of the Injury Compensation Program, the handbook in itself is not sufficient for the effective management of this program.

To effectively manage the program, IC personnel should establish a reference library including, but not limited to, the documents listed below.

The Federal Employees' Compensation Act, as amended, 5 U.S.C. 8101, et seq.

Copies of FECA may be obtained from the OWCP district office.

Code of Federal Regulations, 20 CFR 10

The *Code of Federal Regulations* (CFR) describes the provisions of the law and contains additional information concerning administration of the program. Part 10 provides helpful information for developing local procedures and responding to local inquiries. Copies may be obtained from the OWCP district office.

Federal (FECA) Procedure Manual, Part 2, Claims

The FECA PM describes the procedures used by OWCP personnel in processing claims. This manual can be of great assistance in determining whether to controvert or challenge a claim in some questionable cases. Periodic revisions made by OWCP are distributed by USPS Headquarters and area offices. For optimum benefit, it is imperative that this manual be updated with current information.

Requests for a copy should be directed to:

DIVISION OF FEDERAL EMPLOYEES' COMPENSATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
200 CONSTITUTION AVE NW
WASHINGTON DC 20210-0001

Federal (OWCP) Procedure Manual, Part 3, Rehabilitation

The *Federal (OWCP) Procedure Manual* (OWCP PM) contains procedures for OWCP's vocational rehabilitation program. Like the FECA PM, the OWCP PM provides insight into the criteria followed by OWCP. Ordering and maintenance procedures for this manual are the same as cited for the FECA PM.

Pamphlet CA-550, Questions and Answers About the Federal Employees' Compensation Act

Describes in nontechnical language the basic provisions of the law and includes information concerning the most common issues about entitlement and claims processing. It is intended for use primarily by employees. Copies may be ordered from material distribution centers.

Decisions of the Employees' Compensation Appeals Board

ECAB is the highest authority for appeals review in federal workers' compensation claims. Board decisions are often precedent setting and can result in revision of guidelines by OWCP. A familiarity with ECAB decisions, particularly high-profile decisions, is extremely helpful when preparing controversion and challenge packages. Copies of relevant ECAB decisions are disseminated by USPS Headquarters and area offices. Decisions and summaries are also available in various formats from private contractors.

Publication CA-810, Injury Compensation for Federal Employees, February 1994

Publication CA-810 was prepared by OWCP and is intended to serve as a handbook for all federal agencies. It provides basic information regarding the administration of FECA. Like 20 CFR, Part 10, this publication can be extremely helpful when developing local procedures and responding to local inquiries.

Handbook EL-515, Joint Rehabilitation Guidelines, May 1992

Handbook EL-515 was a joint venture by the USPS and DOL to provide procedures and guidelines for rehabilitation program efforts.

Employee and Labor Relations Manual 540, Special Postal Bulletin, August 2, 1990

The *Employee and Labor Relations Manual* (ELM) 540 was prepared by the USPS. It lists policies and procedures in compliance with FECA and its related regulations.

Administrative Support Manual 353, Privacy Act

The *Administrative Support Manual* (ASM) 353 includes instructions for applying the Privacy Act and the USPS regulations that implement it. Those who handle IC case files and payment records must be familiar with their Privacy Act responsibilities.

Management Instruction EL-540-91-1, Job-Related First-Aid Injuries

This management instruction provides policies and procedures for reporting injuries to OWCP, for determining choice of physician, and for paying medical bills to contract physicians for initial treatment of job-related first-aid injuries.

Publication 540, A Guide for Managing Injuries, November 1994

Publication 540 provides guidance to field managers in establishing or supplementing procedures for the early management of IC claims.

Handbook F-21, Time and Attendance, October 7, 1988, and Handbook F-22, PSDS Supervisor's Guide, May 1992

These handbooks address specific pay issues relevant to injured workers.

Forms and Notices

Many forms are used to collect information needed in the administration of the Injury Compensation Program, some from OWCP, and some from the USPS. It is important for IC personnel to be aware of their uses and comply with the required time frames for submitting them.

CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

The CA-1 notifies management of a traumatic injury and serves as the report to OWCP, when needed.

The employee, or someone acting in his or her behalf, should submit the CA-1 to the supervisor as soon as possible following injury but no later than 30 days for COP entitlement. Statutory requirements will be met for FECA benefits if the CA-1 is filed within 3 years from the injury.

The supervisor should submit this form to the ICCO within 24 hours from receipt from the employee.

The ICCO must submit this form to OWCP within 10 working days from the date received by the supervisor (or other postal official) from the employee.

CA-2, Notice of Occupational Disease and Claim for Compensation

The CA-2 notifies management of an occupational illness or disease and serves as the report to OWCP, when needed.

Statutory requirements will be met if filed within 3 years from date of awareness.

The supervisor submits this form to the ICCO within 24 hours.

The ICCO submits this form to OWCP within 10 working days from the date received by the supervisor or other postal official.

CA-2a, Federal Employee's Notice of Recurrence of Disability and Claim of Pay/Compensation

The CA-2a notifies management and OWCP that an employee, after returning to work, is again disabled because of a prior injury or occupational illness. It also serves as a claim for continuation of pay or for compensation. Immediately upon notification, the ICCO or the supervisor provides the employee with CA-2a.

The employee completes Part A and returns the form. If received by the supervisor, the form must be submitted to the ICCO within 24 hours.

The ICCO submits this form to OWCP within 10 working days from receipt of the form from the employee.

CA-3, Report of Termination of Disability and/or Payment

The CA-3 notifies OWCP that the employee has returned to work and/or that continuation of pay has terminated.

Immediately upon the employee's return to work, the ICCO submits the CA-3 to OWCP. The CA-3 is the preferred form recognized by both agencies even though the employee's return to work may be reported on the CA-7 or the CA-17.

CA-5, Claim for Compensation by Widow, Widower, and/or Children

The CA-5 serves as the official notice to the OWCP of the surviving widow's, widower's, and/or children's claim for compensation because of the employee's death which resulted from a job-related injury.

Upon notification, the ICCO provides the appropriate dependent with the form. The dependent, or representative, should complete the form within 30 days (but no later than 3 years after death) and return it to the ICCO. (If death resulted from an injury for which a disability claim was timely filed, the time requirements for filing the death claim have been met.)

CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

The CA-5b provides claims compensation for specified dependents when the injury results in the employee's death.

The ICCO submits the CA-5b to OWCP within 10 working days from date of receipt from the dependent.

The time requirements for CA-5b are the same as for CA-5.

CA-6, Official Superior's Report of Employee's Death

The CA-6 notifies OWCP of the employment-related death of an employee.

The ICCO submits the CA-6 to OWCP within 10 working days after knowledge of the job-related death.

CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease

The CA-7 is used to claim compensation if (1) injury has resulted in permanent impairment involving the total or partial loss, or loss of use, of certain parts of the body or serious disfigurement of the face, head, or neck; or (2) medical evidence shows disability is expected to continue beyond the COP period in traumatic cases and results in wage loss.

When disability is expected to extend beyond the COP period in traumatic injury cases, the ICCO provides the employee with a CA-7 10 days before the end of the COP period. The employee is instructed to complete his or her portion, have the attending physician complete the CA-20. The ICCO submits the completed CA-7 to OWCP not less than 5 working days before termination of COP.

In occupational disease or illness cases, a CA-7 should be submitted along with the CA-2 if the disability is being claimed at that time. In other instances, the CA-7 is completed and submitted to OWCP not more than 5 days after the period claimed by the employee.

CA-8, Claim for Continuing Compensation on Account of Disability

The CA-8 provides claims compensation when disability continues beyond the time covered by the claim filed on the CA-7.

CA-8s are filed on a recurring basis (usually every 2 weeks) until advised otherwise by OWCP.

If disability is expected to continue, the ICCO provides the employee with the CA-8 at least 10 days before the end of the time indicated on either the CA-7 or the previous CA-8. The employee completes his or her portion, and has the attending physician complete the CA-20a.

The ICCO submits the completed CA-8 to OWCP at least 5 days before the end of the period claimed on the CA-7 or the previous CA-8.

CA-10, What a Federal Employee Should Do When Injured at Work

The CA-10 provides employees with information regarding their rights, responsibilities, and benefits under FECA.

The CA-10 is to be posted on employee bulletin boards.

CA-11, When Injured at Work

This pamphlet provides facts about medical benefits, disability, compensation for death, and other entitlements for civilian employees of the federal government.

The CA-11 should be handed out during employee orientation.

CA-13, Work Injury Benefits for Federal Employees

The CA-13 is a card for federal employees to carry in their wallets as a reference. It provides instructions for employees and their families in the event of an employment-related injury or death.

The CA-13 should be handed out during employee orientation.

CA-16, Authorization for Examination and/or Treatment

The CA-16 authorizes an injured employee to obtain examination and/or treatment for up to 60 days and provides OWCP with an initial medical report.

The CA-16 forms are issued by the ICCO or trained control point personnel only.

The CA-16 must be promptly issued within 4 hours in traumatic injuries requiring medical attention, except first-aid injuries where the employee has elected treatment by a contract medical provider. CA-16s are rarely used for occupational illness or disease claims and only with prior OWCP approval. If the employee chooses to select a contract medical provider beyond first-aid treatment, the CA-16 should be issued in accordance with FECA for the employee's selection of the contract medical provider as the employee's treating physician.

CA-17, Duty Status Report

The CA-17 provides management and OWCP with an interim medical report containing information as to the employee's ability to return to any type of work. Initially issued by the supervisor at the time of injury, subsequent issuances are performed by either the ICCO or control point personnel. The employee is responsible for having the attending physician complete the CA-17 at each visit when there is a change in medical condition and for its prompt return to the ICCO or control point.

The ICCO submits the completed form to OWCP within 10 days from date of receipt.

CA-20, Attending Physician's Report

The CA-20 provides medical support for claims and is attached to the CA-7, which provides the ICCO and OWCP with medical information.

The CA-20 is initially issued by the supervisor at the time of injury when the CA-16 is not used and when the injury is not a first-aid injury treated by a contract medical provider. Subsequent issuances are the same as for the CA-17. CA-20 must be submitted promptly to OWCP upon completion of most recent examination or treatment.

CA-20a, Attending Physician's Supplemental Report

The CA-20a provides OWCP with additional medical information in connection with a supplemental claim filed on an attached CA-8. A corresponding CA-20a is to be submitted with each CA-8 filed. The CA-20a must be submitted promptly to OWCP upon completion of most recent examination or treatment.

Evidence Required in Support of a Claim for

35A*, Occupational Disease*

35B, *Work-Related Hearing Loss*

35C, *Asbestos-Related Illness*

35D, *Work-Related Coronary/Vascular Condition*

35E, *Work-Related Skin Disease*

35F, *Work-Related Pulmonary Illness (not asbestosis)*

35G, *Work-Related Psychiatric Illness*

35H, *Work-Related Carpal Tunnel Syndrome*

The 35A-through-H series of forms provides employee and management with a checklist of information required from both parties in order for OWCP to adjudicate the respective occupational illness or disease claim.

These forms should be submitted with the CA-2.

HCFA-1500, Health Insurance Claim Form

This form provides OWCP with a standard billing form to facilitate payment of medical bills.

The HCFA-1500 is issued along with the CA-16, the CA-20, and the CA-17 when the employee is scheduled for medical examination and/or treatment.

Form 2491, Medical Report — First-Aid Injuries

Form 2491 provides management with a medical report containing information regarding the employee's ability to return to work. This form is used in lieu of the CA-16/20 and the CA-17 when the employee is being treated for a first-aid injury by a contract medical provider.

Form 2491 is issued by the ICCO or control point personnel or the supervisor at the time of injury (initial examination or treatment) and follow-up visit.

Form 2556, Third Party Statement of Recovery

Form 2556 provides OWCP and the USPS with a breakdown of disbursements made from monies recovered from a third party pursuit. This form is used when the employee is represented by an attorney or has assigned the action to the USPS.

When the employee is represented by an attorney, the ICCO issues this form directly to the attorney upon notification. Upon the employee's recovery, the form must be completed promptly and forwarded to OWCP with a check for the government's lien by the ICCO.

Form 2557, Employee's Third Party Recovery Statement

Form 2557 provides OWCP and the USPS with a breakdown of monies recovered by the employee when pursuing his or her own third party action.

The ICCO issues this form promptly to the employee upon notification that he or she is pursuing his or her own action. Upon recovery, the employee returns the form to the ICCO, along with a check for the government's lien, for prompt referral to OWCP.

Form 2559, Third Party Claim — Information Request

Form 2559 provides information about the employee's action (or intended action) regarding the pursuit of a third party action.

This form is issued by the ICCO when the employee's response on Form 2562 was negative or undecided.

Form 2560, Referral of Third Party Material

This form is the cover letter for the transmittal of third party documents and information.

It is used by the ICCO when forwarding third party material.

Form 2562, Injury Compensation Program — Notice of Potential Third Party Claim

Form 2562 provides general information regarding a potential third party and the employee's intent.

This form is issued by the ICCO to the employee upon notification of a possible third party liability. The employee promptly completes the form and returns it to the ICCO for referral to OWCP.

Form 2573, Request — OWCP Claim Status

Form 2573 provides a standard format for requesting general claim status information from OWCP.

The form is used by the ICCO when needed.

Form 2577, Assignment of Claim to the USPS

Form 2577 provides the USPS with the authority to pursue a third party recovery.

This form is issued by the ICCO to the employee upon notification of the employee's lack of intent to take personal action. If in agreement, the employee completes and returns the form to the ICCO for referral to OWCP.

Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act

When an employee is absent from work because of an FMLA-covered injury or illness, a copy of Publication 71 is given to him or her along with the modified letter called Employee Rights, Responsibilities, and Choice of Physician (see Exhibit 3.5b).

2. Injury Compensation Office Setup

Overview

Procedures

Injury Compensation Unit

When forming an injury compensation unit...

2.1 Authorizing Injury Compensation Positions . . . . . *district HR manager*

2.2 Supplying an Adequate Stock of Forms, Sample Letters, and Supplies . . . . . *senior IC specialist*

2.3 Supplying Office Equipment . . . . . *district HR manager*

2.4 Centralizing the Processing of IC Forms and Paperwork and the Management of Claims . . . . . *district HR manager or senior IC specialist*

2. Injury Compensation Office Setup

Overview

The injury compensation (IC) office or unit serves as the injury compensation control office (ICCO). To effectively manage the Injury Compensation Program and control compensation costs, the IC unit must:

— Be organized in a manner that centralizes the processing of administrative paperwork.

— Promote efficiency through the training of IC personnel as well as managers and supervisors.

— Facilitate the administrative duties and responsibilities of IC personnel by utilizing the Human Resource Information System (HRIS) and the Workers' Compensation Information Subsystem (WCIS).

— Be large enough to accommodate file cabinets and a lektriever and have at least one conference area to allow for privacy while interviewing employees or preparing and discussing individual compensation cases.

Because of the complexities of IC policies, procedures, and regulations, the unit should have all resource materials identified in Chapter 1 available for guidance and reference.

Procedures

Injury Compensation Unit

When forming an injury compensation unit...

2.1 Authorizing Injury Compensation Positions — *district HR manager*

☐ Fill the following authorized IC positions:

— Senior IC specialist.

— HR specialists.

— HR associates.

☐ Clearly define all duties and responsibilities of IC personnel so they will be held accountable for their specific areas, programs, and compensation cases.

2.2 Supplying an Adequate Stock of Forms, Sample Letters, and Supplies — *senior IC specialist*

☐ Supply your unit with the following forms:

- All CA and PS forms identified in Chapter 1.
- Leave repurchase forms.
  - Form 2240, *Pay, Leave, and Other Hours Adjustment Request.*
  - Form 2243, *PSDS Hours Adjustment Record.*
  - Form 3971, *Request for or Notification of Absence.*

SEE Appendix D, Forms.

☐ Supply your office with the following correspondence:

- Limited duty accommodations/acceptance or rejection of limited duty (see exhibits in Chapter 7, Limited Duty Program Management).
- Leave repurchase policy notification (see Exhibit 4.19b, Sample Letter: Leave Buy Back Policy).
- COP authorization (see Chapter 4, Claims Management).
- Third party liability letters (see exhibits in Chapter 10, Third Party Liability).
- Health benefit refund (see Chapter 4, Claims Management).
- Basic controversion letter (see exhibits in Chapter 8, Controversion and Challenge).

☐ Furnish your office with the following office supplies:

- Sturdy file folders with two-pronged fasteners on both sides. Do not use official personnel folders (OPFs).
- Copy paper, legal pads, pencils, pens, paper clips, stapler, etc.
- Bulletin board.

2.3 Supplying Office Equipment — *district HR manager*

☐ Supply your office with the following office equipment:

- Desks with telephones.
- Facsimile machine.
- Telephone answering machine.
- Computers and printers.
- Electric typewriter (optional, depending on computer capability).
- Copy machine.
- Document shredder.
- File cabinets and lektriever.
- Partitions.

2.4 Centralizing the Processing of IC Forms and Paperwork and the Management of Claims — *district HR manager or senior IC specialist*

☐ Ensure that IC personnel receive proper training for effective claims management and program administration.

OWCP and USPS Training Courses

IC personnel may enroll in the following OWCP or USPS courses by contacting the OWCP district office or area HR analyst for injury compensation for scheduling.

OWCP

— OWCP Basic Course, Training for Federal Employing Agency Compensation Specialists (3 days).

— Advanced Course for Federal Agency Compensation Specialists (12 hours, self-paced).

USPS

— Injury Compensation Program Administration Course (2 weeks).

— WCIS.

— HRIS.

☐ Arrange to assign the claims equitably among members of the staff.

One common way to assign claims is to split the alphabet between staff members and assign claims according to the last initial of the claimant.

☐ Prepare a comprehensive IC policy and procedure statement to be incorporated in an accident kit so that managers and supervisors will know what to do when an injury occurs.

Establish a procedure for the:

— Main office.

— Station or branches.

— Associate offices.

— Other detached units such as vehicle maintenance facilities (VMFs) and bulk mail centers (BMCs).

The IC policy must:

— Require immediate notification of injury:

  – Injured employees must notify their supervisor if medically able to do so.

  – The supervisor must notify the IC unit. Record essential information on answering machine tape during IC unit off-tour hours.

— Ensure that injured employees receive immediate medical attention following an injury or illness.

- — Ensure that injured employees are informed of their rights and responsibilities, and that entitlements are authorized.
- — Require that all claim forms and related paperwork be submitted through the unit within the specific time frame (normally as soon as possible, but no later than 2 days after receipt from the employee).
- — Ensure that the employee's duty status is ascertained.
- — Ensure that limited duty is made available and offered.

◇ *This policy or procedure statement must be endorsed by the installation head and enforced.*

3. Immediate Involvement With Traumatic Injuries and Occupational Illnesses

Overview

Procedures

Employee Responsibilities

When a new employee is hired...

3.1 Informing Employees of Their Responsibilities . . . . . *supervisor*
Obligation: Notifying OWCP of Traumatic Injury or Occupational Illness or Disease

Supervisor and Control Point Responsibilities in an Emergency

When an emergency work-related accident or illness occurs...

3.2 Initiating Medical Treatment in an Emergency . . . . . *supervisor*
Medical Emergency
3.3 Authorizing Medical Treatment in an Emergency . . . . . *ICCO or control point*
Obligation: Authorizing Medical Examination and/or Treatment

Supervisor and Control Point Responsibilities in a Nonemergency

When a nonemergency job-related accident or illness occurs...

3.4 Notifying the ICCO . . . . . *supervisor*
Obligation: Notifying the ICCO
3.5 Advising the Employee of Rights and Responsibilities . . . . . *supervisor*
Obligation: Advising Employees of Entitled Benefits Under FECA
Obligation: Notifying Employees Whether Absences Count Toward FMLA 12-Week Allowance
FMLA Protection
3.6 Assisting the Employee in Reporting an Injury and Making a Choice of COP or Leave . . . . . *supervisor*
Prima Facie Evidence
3.7 Assisting the Employee in Reporting an Occupational Illness or Disease . . *supervisor*
3.8 Assisting the Employee in Reporting a Recurrence of Disability . . *supervisor or ICCO*
3.9 Initiating Medical Treatment in a Nonemergency . . . *ICCO or designated control point*
Obligation: Ensuring Right to a Free Choice of Physician
Physician
Form 2491, Medical Report — First-Aid Injuries
3.10 Authorizing Medical Treatment in a Nonemergency . . . . . *supervisor or ICCO*
Obligation: Authorizing Medical Examination and/or Treatment
When to Issue CA-16
3.11 Completing and Forwarding Claim Information . . . . . *supervisor*

3.12 Investigating the Claim . . . . . *supervisor acting as control point*
Obligation: Investigating the Injury
Investigation Resources
3.13 Determining Duty Status . . . . . *control point*
3.14 Monitoring the Claim . . . . . *control point*
Obligation: Monitoring Duty Status

Exhibits

3.5a Advising the Employee of Rights, Responsibilities, and the Initial Choice of Physician
3.5b Sample Letter: Employee Rights, Responsibilities, and Choice of Physician
3.5c Sample Letter: Employee Rights, Responsibilities, and Choice of Physician
Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act
Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act
3.13 Injury Action Checklist

3. Immediate Involvement With Traumatic Injuries and Occupational Illnesses

Overview

This chapter addresses the supervisor's role in the event that an employee suffers a work-related traumatic injury or disease or illness. (For information regarding occupational disease or illness claims, see Chapter 4, Claims Management.)

As stated in Chapter 1, one of the main reasons for the development of the USPS Injury Compensation Program was cost control. This objective, however, in no way lessens our primary responsibility for the safety and health of our employees. Accident prevention should always be our first defense. After an accident and subsequent injury have occurred, however, active involvement and claims management at all levels are paramount to accomplishing our cost control and employee welfare goals. Close coordination and cooperation between IC and supervisory personnel are vital to ensure the best interests of both the employee and the USPS.

The employee's supervisor is in an excellent position to ensure that proper and immediate actions are taken following an injury. He or she has firsthand knowledge of the employee, the working environment and, in many cases, the actual circumstances surrounding the injury. It is the supervisor who is there to ensure that the injured employee is provided with his or her benefits and rights under FECA.

In addition to the employee's supervisor, the designated control point also plays an essential role in the early management of the claim. The designated control point initially authorizes, through the issuance of the CA-16, *Authorization for Examination and/or Treatment,* the medical examination and treatment when an injured employee elects an outside physician and hospital (not under contract with USPS), reviews initial medical findings to determine employee's duty status, and determines when the issuance of a CA-16 is not appropriate.

A CA-16 may be issued to a hospital or clinic under contract if the employee elects that provider as a treating physician and the extent of treating the injury is beyond first aid.

Procedures

Employee Responsibilities

When a new employee is hired...

3.1 Informing Employees of Their Responsibilities — *supervisor*

Obligation: Notifying OWCP of Traumatic Injury or Occupational Illness or Disease

FECA requires written notice of a traumatic injury be given within 30 calendar days from the date on which the injury occurs. Failure to give notice within this 30-day period will result in a loss of entitlement to COP as well as a loss of compensation rights in the event that the claim for compensation is not filed within 3 years. The notice of traumatic injury is given on the CA-1.

An employee who believes he or she has developed an occupational disease or illness, or a person acting on behalf of the employee, must give written notice of the disease or illness to the employee's official supervisor. If, for any reason, it is impractical to give notice to the employee's official supervisor, notice of the disease or illness is given to any USPS official or to OWCP. The notice of disease or illness is given on the CA-2.

FECA specifies that notice be given to OWCP within 30 calendar days from the date on which the employee was first aware, or by the exercise of reasonable diligence should have been aware, of a possible connection between the disease or illness and the related factors or conditions of employment. Failure to give notice within this time period may result in a loss of compensation rights in the event that the claim for compensation is not filed within 3 years.

- ☐ During employee orientation, advise employees to report their injuries and illnesses immediately in order to protect their interests, receive prompt medical care, and ensure uninterrupted income.
- ☐ Regularly advise employees of their responsibilities during periodic safety meetings.
- ☐ Ensure that the employee rights and responsibilities are posted on the bulletin board along with local injury compensation policy for reporting injuries.

Supervisor and Control Point Responsibilities in an Emergency

When an emergency work-related accident or illness occurs...

3.2 Initiating Medical Treatment in an Emergency — *supervisor*

Medical Emergency

A *medical emergency* is an injury or sudden and unexpected onset of a condition requiring immediate medical care. Some problems are considered emergencies because, if not treated promptly, they might become more serious (for example, animal bites, eye injuries, deep cuts, broken bones). Others are emergencies because they are potentially life-threatening (for example, heart attacks, strokes, weapon wounds, sudden inability to breathe). In the event that there is a doubt as to the emergent nature of the emergency, it should be handled as an emergency (ELM 543.14).

◇ *If emergency treatment is essential and securing authorization would be impractical, an employee may obtain emergency treatment without prior authorization.*

☐ Immediately ensure that appropriate medical care is provided:

— Advise the employee of his or her right to treatment by a USPS contract medical provider or by a private physician or hospital of his or her choice.

— Arrange for the employee to go to the nearest available physician or hospital or to a physician or hospital chosen by the employee or by the employee's representative.

— In emergency situations, you must accompany the employee to the doctor's office or hospital, or arrange for another supervisor to do so, to ensure that the employee receives prompt medical treatment.

☐ If there is not sufficient time to advise the employee of all rights and responsibilities, advise the employee that he or she must do at least the following, if medically able to do so:

— Submit CA-17, *Duty Status Report,* and other medical evidence to the supervisor or control point within FECA requirements after the examination (or at the start of the employee's next scheduled work shift), so that the employee's duty status may be determined.

— Let the treating physician know of the availability of limited duty and request the physician to provide any limitations imposed by the injury.

— Return Form 2491, *Medical Report — First-Aid Injuries*.

☐ If there is not sufficient time to complete appropriate paperwork (see "When a nonemergency job-related accident or illness occurs..."), arrange to do it after medical care has been provided. Note that:

— Verbal authorization may be given for medical treatment initially and the CA-16 issued within 4 hours (see 3.3, Authorizing Medical Treatment in an Emergency).

— CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation,* should be submitted within 48 hours, if possible.

3.3 Authorizing Medical Treatment in an Emergency — *ICCO or control point*

Obligation: Authorizing Medical Examination and/or Treatment

Initial medical examination and/or treatment must be authorized in accordance with the FECA provisions and applicable OWCP regulations and policies governing medical care. FECA guarantees the employee the right to a free choice of physician.

□ If the injury is an emergency and the employee needs medical attention immediately and selects a private physician or hospital, give verbal authorization and issue CA-16, *Authorization for Examination and/or Treatment*, within 4 hours. Coordinate transportation for the employee to his or her elected medical facility.

◇ *Remember that an injured employee cannot issue a CA-16 for himself or herself. If a person designated to issue a CA-16 becomes injured, the control point at the next higher level of authority would have to issue the CA-16 .*

SEE Chapter 1, USPS Injury Compensation Program.

Supervisor and Control Point Responsibilities in a Nonemergency

When a nonemergency job-related accident or illness occurs...

3.4 Notifying the ICCO — *supervisor*

Obligation: Notifying the ICCO

The supervisor must notify the ICCO immediately or as soon as possible after an injury has been reported.

☐ Notify the ICCO as soon as possible after an injury has been reported. Since most ICCOs are equipped with answering machines, notification can be given on a 24-hour basis.

Give the following information as soon as it is available:

— Name of injured employee.

— Date and time of injury.

— Injury type.

— Brief incident summary.

— Description of medical care provided, if any.

— Employee's duty status.

3.5 Advising the Employee of Rights and Responsibilities— *supervisor*

Obligation: Advising Employees of Entitled Benefits Under FECA

FECA provides that employees who suffer job-related disabilities are entitled to continuation of regular pay up to a maximum of 45 calendar days for a traumatic injury, compensation for wage loss if disability continues beyond 45 days, medical care, schedule awards, and vocational rehabilitation.

Obligation: Notifying Employees Whether Absences Count Toward FMLA 12-Week Allowance

Employees are to be notified in writing if related absences will count toward the 12 workweeks allowed under FMLA and, if so, provided with a copy of Publication 71, *Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act*.

☐ Review rights, responsibilities, and benefits with the employee (see Exhibit 3.5a).

☐ Determine if absences related to the accident or illness are covered by FMLA.

FMLA Protection

Only employees who have accumulated a total of 1 year of postal employment and have actually worked a total of 1,250 hours during the 12 months preceding the absence are eligible for the 12-week FMLA leave allotment.

Eligible employees who are absent because of an on-the-job injury or work-related illness receive FMLA protection if *either* of the following two conditions are met:

— *Hospital care:* inpatient care (i.e., an overnight stay) in a hospital or residential care facility.

— *Absence plus treatment:* a period of incapacity of more than 3 consecutive calendar days that also involves *one* of the following:

  – Treatment, examination, or evaluation of the condition two or more times by a health care provider or health care services provider.

  – Treatment, examination, or evaluation of the condition by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider. A regimen of continuing treatment includes, for example, a course of prescription medication or therapy that requires a visit to a health care provider to initiate.

☐ Provide the employee with the letter called Employee Rights, Responsibilities, and Choice of Physician (see Exhibit 3.5b). If absences are covered by FMLA, use the modified letter (see Exhibit 3.5c) and attach Publication 71, *Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act*. Annotate a copy of the letter with the date that the employee was given the letter so that it can be forwarded to OWCP to be filed in the employee's case file.

☐ Provide the employee with one of the following forms, depending on the situation:

— CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*.

— CA-2, *Notice of Occupational Disease and Claim for Compensation.*

— CA-2a, *Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation.*

☐ Proceed as indicated in 3.6, 3.7, or 3.8, depending on the situation.

3.6 Assisting the Employee in Reporting an Injury and Making a Choice of COP or Leave — *supervisor*

□ Provide the employee with CA-1, *Federal Employee's Notification of Traumatic Injury and Claim for Continuation of Pay/Compensation*. Instruct him or her to do the following:

- — Complete the employee's section of the form.
- — Make choice of treating physician.
- — Elect COP, annual leave, or sick leave if time loss occurs from the job-related injury.
- — Promptly return CA-1 with supporting medical documentation, if available, to the supervisor. If the employee submits medical information later, forward that information to the ICCO for submission with the CA-1, or with the case number, to OWCP.

◇ *The employee is responsible for submitting prima facie medical evidence of disability to the supervisor within 10 working days. If he or she fails to do so, COP can be terminated.*

Prima Facie Evidence

Prima facie evidence is medical evidence that indicates the employee is disabled as a result of a job-related injury and thus cannot perform the job held at the time of injury.

☐ Upon receiving the completed CA-1 from the employee, do the following:

- Document on CA-1 the date the form was received.
- Complete the receipt attached to CA-1 and give a copy to the employee or his or her representative.
- Review the CA-1 for completeness and accuracy, and assist the employee in correcting any deficiencies found.
- Complete the official supervisor's report of traumatic injury, items 17 through 18.
- Inform the employee of his or her right to elect COP or annual or sick leave for time loss resulting from the job-related injury.
- Comment on the employee's narrative statement by either confirming it, refuting it, or providing additional, relevant, and probative information in a separate cover letter to the OWCP.
- Complete Form 1769, *Accident Report*.
- Submit the completed CA-1, a copy of Form 1769, *Accident Report*, and all other documentation to the ICCO within 24 hours of receipt from the employee.
- Inform the employee whether COP will be controverted and whether pay will be terminated in accordance with one of the eight regulatory reasons.
- Explain to the employee his or her responsibility to submit prima facie medical evidence of disability within 10 working days of the date of receipt of the CA-1 from the employee.

3.7 Assisting the Employee in Reporting an Occupational Illness or Disease — *supervisor*

☐ Provide the employee with CA-2, *Notice of Occupational Disease and Claim for Compensation*, and two copies of the appropriate checklist on CA-35 A-H (see Appendix D, Forms, for the individual names of these forms) for the disease reported. Instruct him or her to do the following:

- — Complete the employee's section of the form.
- — Provide all the necessary documentation as outlined in items 1 and 2 under "Instructions for Completing Form CA-2."
- — Promptly return the CA-2 and narrative statement within 2 days, if possible.
- — Provide detailed information for the supporting medical and factual information requested on the checklist.
- — Choose sick leave, annual leave, or leave without pay pending the OWCP adjudication of the claim, if unable to work.
- — Contact the ICCO for further guidance and compensation information.

☐ Upon receiving the completed CA-2 from the employee, do the following:

- — Document on CA-2 the date the form was received.
- — Complete the "Receipt of Notice of Occupational Disease or Illness" and give it to the employee or his or her representative.
- — Review the CA-2 for completeness and accuracy. If incomplete, contact the employee or his or her representative for the missing information and assist the employee in correcting any deficiencies found.
- — Complete the official supervisor's report of occupational disease, items 19 through 34.
- — Comment on the employee's narrative statement by either confirming, refuting, or providing additional, relevant, and probative information in a separate cover letter to OWCP.
- — Complete Form 1769, *Accident Report*.
- — Submit the completed CA-2, a copy of Form 1769, *Accident Report*, and all other documentation to the ICCO within 24 hours of receipt from the employee.

SEE Chapter 1, The USPS Injury Compensation Program.

3.8 Assisting the Employee in Reporting a Recurrence of Disability — *supervisor or ICCO*

☐ Provide the employee with CA-2a, *Federal Employee's Notice of Employee's Recurrence of Disability*, and instruct him or her to do the following:

— Complete part A, items 1 through 23. Provide a narrative statement explaining the circumstances surrounding the current disability and describe the connection between the current condition and job duties to the earlier injury or occupational disease or illness.

— Complete part C, items 1 through 8, only if no longer employed by either the USPS or another federal agency at the time of recurrence. In this case, send the form directly to OWCP.

— Choose COP (if entitled and the 45 calendar days have not been used, and 90 days have not elapsed since first return to duty) or annual or sick leave pending adjudication of the recurrence claim.

☐ Upon receiving CA-2a from the employee, do the following:

— Complete part B, items 24 through 44. Seek assistance from the ICCO, if necessary.

— Forward CA-2a and the employee's statement to the ICCO.

3.9 Initiating Medical Treatment in a Nonemergency — *ICCO or designated control point*

Obligation: Ensuring Right to a Free Choice of Physician

Initial medical examination and treatment must be authorized in accordance with FECA provisions and applicable OWCP regulations and policies governing medical care. FECA guarantees the employee the right to a free choice of physician.

□ Inform the employee of his or her right to treatment by a USPS contract medical provider or by a private physician or hospital of his or her choice:

— Provide the definition of *physician* (if necessary).

— Advise the employee that, at any time, and at his or her own free will, the employee may select a physician or hospital within approximately 25 miles of his or her home or work site.

Physician

A *physician* is any surgeon, podiatrist, dentist, clinical psychologist, optometrist, chiropractor, or osteopathic practitioner used within the scope of his or her practice as defined by state law. Exceptions are as follows:

1. Chiropractors, if their reimbursable services are other than treatment consisting of manual manipulation of the spine to correct subluxation as demonstrated to exist by X ray.
2. Naturopaths, faith healers, and other practitioners of the healing arts, because they are not recognized as physicians within the meaning of FECA.

◇ *In nonemergency situations, a postal supervisor is not authorized to accompany the employee to the medical facility.*

□ Provide the appropriate forms and make arrangements for the employee to see the physician of choice:

— If the employee selects treatment by a USPS contract medical provider, issue the following:

  – Form 3956, *Authorization for Medical Attention*, if it is necessary in your installation.
  – Form 2491, *Medical Report — First-Aid Injuries*.

— If the employee selects a private outside physician or hospital, issue any or all of the following forms (see 3.10, Authorizing Medical Treatment in a Nonemergency):

  – CA-16, *Authorization for Examination and/or Treatment*.
  – CA-17, *Duty Status Report*.
  – CA-20, *Attending Physician's Report*.

- HCFA-1500, *Health Insurance Claim Form*.

— If the employee does not select a physician, refer the employee to the USPS contract medical provider for diagnosis and initial evaluation, advising the employee that he or she may select a physician of choice after initial evaluation by the contract medical provider in accordance with ELM 543.1.

  If the employee is to be examined by the USPS contract medical provider before seeking treatment from a private physician or hospital, ensure the following:

  - The examination is performed promptly following the report of the injury.
  - CA-16 is provided for the private physician of choice, within 4 hours of the injured employee's reporting of injury.
  - The USPS examination in no way interferes with or delays the employee's right to seek a prompt examination and treatment from a physician of choice.

Form 2491, *Medical Report — First-Aid Injuries*

Form 2491 is only for USPS provider-treated first-aid injuries and can be used for a maximum of two visits per injury (one initial and one follow-up) to confirm full recovery. If treatment is required beyond the second visit, the injury is no longer considered a first-aid injury, and the same forms must be issued as those needed for treatment when an outside physician or hospital is selected, as set forth in the following section. (This is true even if the employee continues treatment with the contract medical providers.)

□ Refer the employee to the IC unit for assistance if he or she wishes to change his or her treating physician.

◇ *For continued payment of medical expenses by OWCP, a change of the employee's initial choice of physician is permitted only with OWCP approval.*

3.10 Authorizing Medical Treatment in a Nonemergency — *supervisor or ICCO*

Obligation: Authorizing Medical Examination and/or Treatment

Initial medical examination and/or treatment must be authorized in accordance with the FECA provisions and applicable OWCP regulations and policies governing medical care. FECA guarantees the employee the right to a free choice of physician.

□ In a nonemergency, determine if CA-16 issuance is required, as shown in the information block below.

— If it is required, issue the employee the form within 4 hours.

— If it is not required, provide a CA-17, *Duty Status Report*, and CA-20, *Attending Physician's Report,* to the employee for completion by the treating physician.

◇ *The CA-20 is attached to CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease. When used as mentioned above, it is to be detached from the CA-7.*

When to Issue CA-16

Issue CA-16 to authorize medical treatment:

— For all traumatic injuries requiring medical attention when the employee elects outside treatment, even if the initial treatment is provided by the contract physician, except as cited below.

— When the injured employee elects the USPS contract medical provider for continued medical treatment beyond the first-aid care (after the first two visits).

— Following a recurrence of disability, provided the ICCO agrees.

You must have concurrence by the ICCO for recurrence cases.

Do not issue CA-16 to authorize medical treatment:

— For first-aid injuries when medical care is provided by a USPS contract medical provider for the first two visits and the employee voluntarily accepts this care.

— Following the submission of an occupational disease or illness claim (CA-2) or an occupational disease or illness recurrence claim (CA-2a) that has not been accepted by OWCP.

Issuance of CA-16s for an occupational disease or illness claim must have prior OWCP approval. Refer all inquiries to the IC unit.

— At some future time or as the need arises.

Advanced or blanket authorization is not to be given. Advise employees who ask for it to contact OWCP in writing.

Do not issue CA-16 to authorize a change of physicians after the initial choice has been made. Refer the employee to the ICCO.

☐ When the employee elects a physician of choice, ask the employee to contact the selected physician by telephone to determine if the physician is available and will accept the employee for treatment. If not, the employee should be encouraged to select another qualified physician or hospital in order to obtain prompt medical care. Inform the employee of his or her obligation to advise the physician of the availability of limited duty, letting the physician know that the USPS will accommodate most restrictions.

◇ *USPS personnel must not interfere with the medical care prescribed by the employee's attending physician. Supervisory contact with a physician or a physician's staff is to be limited to inquiries regarding the employee's duty status (see 4.5, Reviewing the Medical Documentation to Assess the Duty Status).*

☐ Complete your portion of the following forms and give them to the employee:

— CA-16, *Authorization for Examination and/or Treatment,* or CA-20, *Attending Physician's Report*.

— CA-17, *Duty Status Report*.

— HCFA-1500, *Medical Provider's Claim Form.*

☐ Advise the employee to report back to you following the examination and treatment, if medically able:

— If you will not be available, let the employee know to whom he or she should report.

— Provide a telephone number to call in case the employee is medically unable to return.

3.11 Completing and Forwarding Claim Information — *supervisor*

☐ If the employee elects either COP or sick or annual leave on a CA-1, ensure that Form 3971, *Request for or Notification of Absence,* is:

— Complete for periods of disability beyond the day of injury.

— Authorized by the IC unit.

◇ *Form 3971 cannot be filed until the employee completes a CA-1. Until a CA-1 is filed, the employee's time must be charged to either sick or annual leave or leave without pay (LWOP) in accordance with ELM 510, Employee Benefits.*

SEE Chapter 13, Timekeeping and Accounting.

☐ Coordinate employee's duty status with the designated control point.

When the employee is capable of returning to the work site following initial examination and treatment, the control point will review available medical documentation and determine if the employee is capable of returning to either full or limited duty.

☐ Upon completion of the CA-1, CA-2, or CA-2a — as soon as possible but no later than 24 hours following receipt from the employee — forward the claim package to the IC unit.

— Submit the following documents, if available and applicable:

– Form 3971.

– Form 2491.

– CA-17.

– Other medical evidence or pertinent information.

– Employee's Rights and Responsibilities sample letter.

— Submit to the ICCO a copy of the investigation report (i.e., Form 1769, *Accident Report,* or other written accident reports), if available, so that ICCO personnel may decide if there are grounds to controvert or challenge the claim.

◇ *Do not delay the CA-1 pending completion of the investigation.*

☐ Maintain contact with the ICCO to ensure that the claim is properly managed and the employee is provided his or her rights under FECA.

3.12 Investigating the Claim — *supervisor acting as control point*

Obligation: Investigating the Injury

According to FECA, the USPS does not have the right to participate actively in the claims adjudication process. However, the USPS may investigate the circumstances surrounding an injury to an employee and the extent of the employee's disability.

☐ Begin an investigation of the claim immediately upon notification that an injury has occurred:

— Investigate the circumstances surrounding the injury and write down any facts you find.

— If necessary, contact the ICCO and safety office so that they also may become involved in the investigation. The results of the investigation should either substantiate the claim or show doubt as to its validity.

Investigation Resources

Some of the sources and expertise available during the investigation include:

— Injured employee.

— Witnesses.

— Immediate supervisor and unit manager.

— Medical evidence.

— Safety staff.

— IC unit staff.

— Inspection Service.

— Official personnel folder.

— Vehicle accident investigator.

— Law enforcement agency.

☐ Determine, if possible, if a third party liability exists.

If the investigation reveals that the injury was caused by a person or organization not under the employ of the USPS or other federal agency, annotate the appropriate block on the CA-1.

SEE Chapter 10, Third Party Liability.

☐ After the investigation is complete, write a detailed report of your findings.

◇ *Timely submission of reports is critical for proper processing, administration, and referral to OWCP within the established time frame of 10 working days from date* of USPS receipt from employee.

3.13 Determining Duty Status — *control point*

☐ Review initial medical findings, determine employee's duty status, and assign the employee as follows:

— Fit for full duty — return the employee to his or her regular assignment.

— Fit for limited duty — place the employee in an assignment that accommodates his or her medical restrictions.

— Not fit for duty — before the end of the employee's work shift on the day of injury, charge the remaining scheduled time to administrative leave. Beginning the next full day or work shift, the employee will be placed in the status annotated on the CA-1, either COP or sick or annual leave. Sick leave, annual leave, or LWOP will be used until accrued leave is exhausted (ELM 510). The employee will then be placed in a (leave without pay/injured on duty) LWOP-IOD status (see Chapter 7, Limited Duty Program Management, and Chapter 13, Timekeeping and Accounting.)

☐ Ensure that all medical documentation is forwarded to the ICCO and all necessary actions have been taken.

☐ Coordinate with employee's supervisor and review action items listed on Injury Action Checklist (see Exhibit 3.13).

3.14 Monitoring the Claim — *control point*

Obligation: Monitoring Duty Status

The USPS monitors the employee's medical progress and duty status by obtaining periodic medical reports.

☐ Maintain contact with IC unit and supervisor. If the employee has been found not fit for duty, close coordination is instrumental in facilitating a return to work status as early as medically possible.

Exhibit 3.5a

Advising the Employee of Rights, Responsibilities, and the Initial Choice of Physician

To make sure that the employee understands his or her rights and responsibilities:

— Provide the employee the sample letter called Rights, Responsibilities, and Initial Choice of Physician (see Exhibit 3.5b).

— Counsel the employee regarding rights and responsibilities, using the following summary, which is more detailed than that in the letter.

Continuation of Pay or Sick or Annual Leave

If the injury is disabling, the employee may elect to use one the following:

a. Continuation of Pay

COP may be used in the case of job-related injury for a period not to exceed 45 calendar days.

(Also see Chapters 4 and 13 for additional information regarding COP.)

If the employee elects COP, he or she must:

(1) Annotate the appropriate block on CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.*

(2) Complete Form 3971, *Request for or Notification of Absence*.

Advise the employee that:

(1) He or she has the right to select COP, annual leave, or sick leave.

(2) He or she is responsible for submitting or arranging for the submittal of prima facie medical evidence of a traumatic disabling injury within 10 working days after claiming COP. Prima facie evidence is medical evidence that indicates the employee is disabled as a result of a job-related injury and thus cannot perform the job held at the time of injury. Under the provisions of 20 CFR 10.204(a)(1), if such evidence is not received within that time frame, it may serve as sufficient reason for termination of COP, subject to reinstatement upon receipt of such evidence.

b. Sick or Annual Leave

If the employee elects sick or annual leave, he or she must:

(1) Annotate the appropriate block on CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.*

(2) Complete Form 3971, *Request for or Notification of Absence*.

Advise the employee that:

(1) The use of annual or sick leave does not extend the 45-calendar-day COP period that begins with the first period of time lost after the day or shift of injury.

(2) Leave is limited to the amount that the employee has accrued.

(3) An employee who elects to use sick or annual leave during the 45-day period in which COP is available is not entitled to buy back that leave with later compensation payments. (ELM 545.73b)

(4) The employee may subsequently request COP instead of previously requested sick and/or annual leave. However, such a request must be made within 1 year of the date that leave is used, or within 1 year of the date OWCP approves the claim, whichever is later. If COP is granted, then the employee's sick and annual leave used for the period of time covering the absences for the injury will be credited to the employee's leave balance.

(5) Pay attributable to the leave period (COP, sick leave, or annual leave) is subject to taxes and other usual payroll deductions.

Note: ICCO authorization is not required for the employee to use sick or annual leave.

Compensation

If disability extends beyond the 45-day COP entitlement period, the employee is entitled to file with the OWCP for compensation payments.

Medical Care

Injured employees are entitled to receive medical and related services made necessary by the medical condition or conditions accepted as being job-related. These services are provided by a physician or hospital of the employee's choice. When possible, the employee's choice of physician should be in writing and made part of the claim file. The sample letter Employee Rights, Responsibilities, and Choice of Physician will serve this purpose (see Exhibit 3.5b).

For continued payment of medical expenses by OWCP, a change of the employee's initial choice of physician is permitted only with OWCP approval. If an employee wishes to change his or her treating physician, refer the employee to either the ICCO or OWCP for assistance.

Return to Duty

Advise the employee of his or her obligation to return to duty (either full or limited) as soon as possible. To fulfill this obligation, the employee must:

a. Advise the attending physician that the USPS will accommodate most limitations.

b. Request that the physician specify the limitations and restrictions imposed by the injury.

c. Immediately advise the supervisor or control point of those limitations and restrictions.

If the USPS has identified specific alternative positions available, advise the employee to do the following:

a. Furnish the attending physician the description of such alternative positions.

b. Inquire whether and when he or she will be able to perform such duties.

c. Furnish the supervisor, the ICCO, or the control point with a copy of the physician's response.

Schedule Awards

Eligible employees may be entitled to a schedule award, defined as compensation for the permanent loss, or loss of use, of each of certain members, organs, and functions of the body. Refer employees to the ICCO or OWCP for assistance if this should occur.

Vocational Rehabilitation

OWCP's policy is to assist permanently disabled employees, injured on the job, to return to gainful employment within their medically defined work restrictions. Consideration in the return-to-work effort is always given first to the previous employer.

Advise employees that if they become eligible for participation in this program, they will be contacted by OWCP and/or the USPS ICCO. Employees may also request consideration.

Exhibit 3.5b

Sample Letter: Employee Rights, Responsibilities, and Choice of Physician

*Variant for Employee Absences **Not** Covered by Family and Medical Leave Act (FMLA)*

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Dear ___[name]___:

This letter is in regard to your job-related traumatic injury of ___[date]___.

In view of your recent injury, we would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA). FECA benefits include but are not limited to the following:

- Initial choice of physician to provide medical examination and/or treatment.*
- Payment of injury-related medical expenses.
- Up to 45 calendar days of continuation of pay (COP).
- Compensation for wage loss after the 45-calendar-day COP period expires.
- Compensation for permanent impairment of specified members and functions of the body.
- Vocational rehabilitation services.
- Death and/or survivor benefits.

* In nonemergency situations, you should advise your supervisor, medical unit, or injury compensation control office or point of initial choice of physician before treatment. This will allow for timely issuance of the appropriate medical authorization forms.

While FECA provides for the above benefits, it also places certain responsibilities on the injured employee. Specifically, it is your responsibility to:

- Complete and submit the employee's portion of CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, to your supervisor as soon as possible.
- Arrange for the submission of prima facie (i.e., true, valid, and sufficient at first impression) medical evidence of a traumatic disabling injury to your supervisor, medical unit, or injury compensation control office or point within 10 working days after claiming COP. Failure to provide medical evidence may result in termination of COP.

- If limited duty work is available and offered, you must notify your attending physician and request him/her to specify the limitations and restrictions that apply. Thereafter, immediately advise your supervisor, medical unit, or injury compensation control office or control point of the limitations and restrictions imposed by your physician.
- If offered limited duty work within the limitations and restrictions imposed by your attending physician, you are obligated to return to duty unless you request leave under FMLA.

In assigning limited duty, we will follow the provisions of the *Employee and Labor Relations Manual* (546.141a) so as to minimize any adverse disruptive effect on you.

Injury compensation control office or control point personnel are available to provide guidance or assistance on matters related to your injury. Additionally, such personnel will do everything possible to ensure timely receipt of benefits. If you have any questions whatsoever, visit or call the injury compensation unit at ___[telephone number]___ or contact your local OWCP.

We wish you a full and speedy recovery.

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Exhibit 3.5c

Sample Letter: Employee Rights, Responsibilities, and Choice of Physician

Variant for Employee Absences Covered by Family and Medical Leave Act (FMLA)

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Dear ___[name]___:

This letter is in regard to your job-related traumatic injury of ___[date]___.

In view of your recent injury, we would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA). FECA benefits include but are not limited to the following:

- Initial choice of physician to provide medical examination and/or treatment.*
- Payment of injury-related medical expenses.
- Up to 45 calendar days of continuation of pay (COP).
- Compensation for wage loss after the 45-calendar-day COP period expires.
- Compensation for permanent impairment of specified members and functions of the body.
- Vocational rehabilitation services.
- Death and/or survivor benefits.

* In nonemergency situations, you should advise your supervisor, medical unit, or injury compensation control office or point of initial choice of physician before treatment. This will allow for timely issuance of the appropriate medical authorization forms.

You are also eligible for protections provided by FMLA, since your absence qualifies as a serious health condition that is covered by that Act.

While FECA provides for the above benefits, it also places certain responsibilities on the injured employee. Specifically, it is your responsibility to:

- Complete and submit the employee's portion of CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, to your supervisor as soon as possible.
- Arrange for the submission of prima facie (i.e., true, valid, and sufficient at first impression) medical evidence of a traumatic disabling injury to your supervisor, medical unit, or injury compensation control office or point within 10 working days after claiming COP. Failure to provide medical evidence may result in termination of COP.

— If limited duty work is available and offered, you must notify your attending physician and request him/her to specify the limitations and restrictions that apply. Thereafter, immediately advise your supervisor, medical unit, or injury compensation control office or control point of the limitations and restrictions imposed by your physician.

— If offered limited duty work within the limitations and restrictions imposed by your attending physician, you are obligated to return to duty unless you request leave under FMLA. If you choose not to accept the limited duty job offer, you may not be entitled to COP or wage loss compensation under FECA. However, you are not obligated to accept such duty during the period of FMLA protection, provided you are willing to forgo the FECA wage loss payments.

In assigning limited duty, we will follow the provisions of the *Employee and Labor Relations Manual* (546.141a) so as to minimize any adverse disruptive effect on you.

Injury compensation control office or control point personnel are available to provide guidance or assistance on matters related to your injury. Additionally, such personnel will do everything possible to ensure timely receipt of benefits. If you have any questions whatsoever, visit or call the injury compensation unit at ___[telephone number]___ or contact your local OWCP.

We wish you a full and speedy recovery.

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachment: Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act.

Attachment for Exhibit 3.5c

Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act

UNITED STATES POSTAL SERVICE™

Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act

I. Qualifying Conditions

The Family and Medical Leave Act (FMLA) provides that employees meeting the eligibility requirements must be allowed to take time off for up to 12 workweeks in a leave year for the following conditions:

1. Because of the birth of a son or daughter (including prenatal care), or to care for such son or daughter. Entitlement for this condition expires 1 year after the birth.
2. Because of the placement of a son or daughter with you for adoption or foster care. Entitlement for this condition expires 1 year after the placement.
3. In order to care for your spouse, son, daughter, or parent who has a serious health condition. Also, in order to care for those who have a serious health condition and who stand in the position of a son or daughter to you or who stood in the position of a parent to you when you were a child.
4. Because of a serious health condition that makes you unable to perform the functions of your position.

II. Eligibility

To be covered by FMLA, you must have been employed by the Postal Service for a total of at least 1 year *and* must have worked a minimum of 1,250 hours during the 12-month period before the date your absence begins.

III. Type of Leave or Pay

The time off counted toward the 12 workweeks allowed for the qualifying conditions can be any one or combination of the following:

- Time off you take as annual leave, sick leave, and/or LWOP in accordance with current leave policies.
- In the case of job-related injuries or illnesses, time off during which you are receiving continuation of pay (COP) and/or time during which you are placed on the Office of Workers' Compensation Program (OWCP) payroll.

Note that sick leave is available only for your own health condition except for the situations specifically designated in postal policy or collective bargaining agreements.

IV. Documentation

Supporting documentation is required for your leave request to receive final approval. Documentation requirements may be waived in specific cases by your supervisor.

- For qualifying condition (1) or (2), you must provide the birth or placement date.
- For conditions (3) or (4), you must provide documentation from the health care provider stating:
  1. The health care provider's name, address, phone number, and type of practice, and the patient's name.
  2. A certification that the patient's condition meets the FMLA definition of serious health condition, supporting medical facts, and a brief statement as to how the medical facts meet the definition's criteria.
  3. The approximate date the serious health condition commenced, its probable duration, and the probable duration of the patient's present incapacity, if different.
  4. Whether you will need to take leave intermittently or to work on a reduced schedule as a result of the serious health condition; and if so, the probable duration of such schedule, an estimate of the probable number of and the interval between episodes of incapacity, and the period required for recovery, if any.

continued

Attachment for Exhibit 3.5c (continued)

Publication 71, Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Act

continued

5. For pregnancy or a chronic serious health condition: whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.
6. If additional or continuting treatments are required: the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and actual or estimated dates of the treatments, if known.
7. For your own serious health condition, including pregnancy or a chronic condition: whether you are unable to perform work of any kind, any parts of your job you are unable to perform, and if you must be absent from work for treatments.
8. To care for a family member with a serious health condition: whether the patient requires assistance for basic medical or personal needs or safety, or for transportation; or if not, whether your presence to provide psychological comfort would be beneficial to the patient or assist in the patient's recovery; and the probable duration of the need for care or an intermittent or reduced work schedule basis. You must indicate on the form the care you will provide and an estimate of the time period.

- If the serious health care condition is a result of a job-related injury or illness, the documentation requirements are provided separately.
- If the time off requested is to care for someone other than a biological parent or child, appropriate explanation of the relationship may be required.

Supporting information that is not provided at the time the leave is requested must be provided within 15 days, unless this is not practical under the circumstances. If the Postal Service questions the adequacy of a medical certification, a second or third opinion may be required. These are obtained off the clock. However, the Postal Service will pay for these opinions, plus reasonable "out of pocket" travel expenses incurred to obtain the opinions.

During your absence, you must keep your supervisor informed of your intentions to return to work and status changes that affect your ability to return. Failure to provide information can result in the denial of family and medical leave under these policies.

V. Benefits

Health Insurance — To continue your health insurance during your absence, you must continue to pay the "employee portion" of the premiums. This continues to be withheld from your salary while you are in a pay status. If the salary for a pay period does not cover the full employee portion, you are required to make the payment. If this occurs, you will be advised of the procedures for payment.

Life Insurance — Your basic life insurance is free and continues. If you are in an LWOP status for more than a year, this coverage is discontinued; in this case you have the option to convert to an individual policy. If you have optional life insurance coverage, it continues. Your premium payments continue to be withheld from your pay check. If you are in a nonpay status, your optional insurance coverage continues without cost for up to 12 month. sThereafter you can convert this coverage to an individual policy.

Flexible Spending Accounts (FSAs) — If you participate in the FSA program, see your employee brochure for the terms and conditions of continuing coverage during leave without pay.

VI. Return to Duty

At the end of your leave, you will be returned to the same position you held when the absence began (or a position equivalent to it), provided you are able to perform the functions of the position and would have held that position at the time you returned if you had not taken the time off.

If the absence is due to your own health condition and exceeds 21 calendar days, you must submit evidence of your ability to return to work before you will be allowed to return.

Exhibit 3.13

Injury Action Checklist

Action	✓ Check
Immediately ensure that medical care is provided to the employee in emergency situations.	
Contact the ICCO immediately or as soon as possible following report of injury.	
Provide the employee with sample letter called Employee Rights, Responsibilities and Choice of Physician (see Exhibit 3.5b).	
Review rights and responsibilities with employee. — Have employee complete and sign the sample letter. — Provide employee with a copy of sample letter.	
Assist employee in completing employee's portion of the CA-1, if necessary.	
Upon submission by employee, complete the receipt portion of CA-1 and return the receipt to the employee.	
Complete supervisor's portion of CA-1.	
Have the employee make an appointment with the physician of employee's choice, if a private physician was elected.	
Issue appropriate medical forms: Form 2491, *Medical Report — First-Aid Injuries*. — CA-16, *Authorization for Examination and/or Treatment* — CA-17, *Duty Status Report*. — CA-20, *Attending Physician's Report*. — HCFA-1500, *Health Insurance Claim Form*.	
Review medical documentation following examination or treatment and determine employee's duty status.	
Make limited duty job offer, if appropriate.	
Issue Form 3971, *Request for or Notification of Absence,* if employee is found unfit for duty.	
Complete investigation of circumstances surrounding injury.	
Forward CA-1 (and all available medical and other pertinent documentation) to the ICCO as soon as possible but no later than within 24 hours from date of receipt from employee.	

NOTE: This checklist is a brief overview of the primary actions that must be taken immediately following an injury. While all of the above actions must be performed, they do not necessarily need to be performed in the listed sequence. The sequence of events will depend on the individual circumstances.

4. Claims Management

Overview

Procedures

Initial Traumatic Injury Claims Management

When the ICCO receives notice of a traumatic injury or death...

4.1 Determining If the Claim Is Reportable . . . . . *ICCO*
Obligation: Submitting the Claim to OWCP in a Timely Manner

4.2 Making an Initial Assessment Following Verbal Notification . . . . . *ICCO*

4.3 Processing Documentation . . . . . *ICCO*

4.4 Reviewing CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay . . . . . *ICCO*

4.5 Reviewing the Medical Documentation to Assess the Duty Status . . . . . *ICCO*
Obligation: Assigning Limited Duty

4.6 Reviewing the Information for Integrity . . . . . *ICCO*

4.7 Submitting the Claim Package to OWCP . . . . . *ICCO*

Initial Occupational Illness or Disease Claims Management

When the ICCO receives notice of a potential occupational illness or disease...

4.8 Responding to Notice of a Potential Occupational Disease or Illness . . . . . *ICCO*

4.9 Reviewing CA-2, Notice of Occupational Disease and Claim for Compensation *ICCO*

4.10 Reviewing the Claim Information for Integrity . . . . . *ICCO*

4.11 Submitting the Claim Package to OWCP or Retaining It . . . . . *ICCO*

Claims Management in Case of Death

When the ICCO receives notice of a death from a traumatic injury or potentially from an occupational disease or illness...

Obligation: Informing Survivors of Compensation in Case of a Death

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When it appears that an employee will remain totally or partially disabled beyond the first 45 days following a traumatic injury...

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4. Claims Management

Overview

This chapter addresses the various claims management stages. Good claims management is a continuing effort and does *not* end at the conclusion of the 45-day COP entitlement period. Claims management continues until the following occurs:

— The injured or ill worker is returned to full duty and medical care is finished.

— His or her disability is ruled by OWCP as being no longer job related.

— The employee's survivor dies or becomes ineligible, and benefits for the survivor cease.

Even when the employee is considered permanently and totally disabled, i.e., never will be able to return to work (RTW) in any capacity, supporting medical information should be reviewed periodically.

The ICCO serves two primary customers — the injured employee and the USPS. IC personnel must ensure that the employee is provided with all the rights and benefits to which he or she is entitled. At the same time, the interest of the USPS must be served by guarding against workers' compensation fraud and abuse.

Serving the interests of these two customers is neither an easy task nor one that the ICCO can accomplish alone. Close coordination and cooperation with all functional areas is absolutely necessary for a successful program. The ICCO is, however, responsible for the day-to-day program administration within the USPS. All claim documents must be tracked through the ICCO for referral to OWCP.

This chapter is divided into six sections. The first three deal with initial claims management. The last three deal with claims management for progressively longer periods:

— Initial traumatic injury claims management — what must be done as soon as the ICCO learns of the injury.

— Initial occupational illness or disease claims management — what must be done as soon as the ICCO learns of the illness or disease.

— Claims management in case of death — what must be done as soon as the ICCO learns of the death.

— Management of the 45-day COP entitlement period — what must be done during the 45-day period.

— Continued claims management — what must be done following the 45-day COP entitlement period during the first year of disability.

— Extended claims management — what must be done when total or partial disability extends beyond 1 year.

Procedures

Initial Traumatic Injury Claims Management

When the ICCO receives notice of a traumatic injury or death...

4.1 Determining If the Claim Is Reportable — *ICCO*

Obligation: Submitting the Claim to OWCP in a Timely Manner

A CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, is completed for job-related traumatic injuries, including first-aid cases. If the injury meets the conditions for reporting to OWCP, the ICCO submits the completed CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay or Compensation*, and any other documents that have some bearing on the claim to the appropriate OWCP office within 10 working days after they are received from the employee.

☐ Determine if the claim is the result of a traumatic injury and is reportable to OWCP by checking the two following lists, and then take one of the following actions:

- File the CA-1 for a "nonreportable" first-aid case, i.e., one that meets all of the following conditions:
  - Treatment is provided by a USPS physician, nurse, or contract medical provider.
  - The initial visit occurs during workhours or nonworkhours on the day or during the shift in which the injury occurred, or during nonworkhours thereafter.
  - The follow-up visit for confirmation of complete recovery occurs during nonworkhours.
  - The employee is able to perform all duties of his or her position.
- File a nonreportable first-aid injury in the employee's official medical folder (OMF) or in the employee's official personnel folder (OPF) if there is no OMF.
- Prepare to report the claim to OWCP in other cases. An injury must be reported if it is likely to result in or has resulted in, any of the following:
  - A reportable first-aid case, i.e., one that is treated by a private physician, or that the employee simply wishes to report.
  - Prolonged treatment beyond first aid, i.e., more than initial and one follow-up visit of medical care.
  - A medical claim charged against OWCP.
  - Disability for work or assignment to limited duty beyond the day or shift of injury.

- Continuation of pay.
- Future disability.
- Permanent impairment.
- Death.

◇ *An employee cannot be required to complete a CA-1 if he or she chooses not to. However, the ICCO should annotate the employee's refusal to complete a CA-1.*

4.2 Making an Initial Assessment Following Verbal Notification — *ICCO*

☐ Determine what the circumstances surrounding the accident were and what actions have been taken by considering the following questions:

- — Was medical care provided by a postal contract medical provider or by a private physician?
- — Was CA-16 used?
- — Were proper forms provided?
- — What is the employee's duty status?
- — Is the medical condition job-related?
- — Is the employee capable of limited duty?
- — Was a limited duty job offer made?
- — When can receipt of the claim forms be expected?

☐ Provide assistance in regard to forms completion, submission, required follow-up actions, etc.

☐ If the injury resulted in an employee fatality, use the guidelines found in 4.12, *Investigating a Death From a Traumatic Injury or Potentially From an Occupational Disease or Illness*.

☐ Notify the district HR manager through the proper chain of command of any serious breakdown in procedure, e.g., failure to provide appropriate medical care.

◇ *If the claim is reportable, the completed CA-1 and any other documents related to the claim will need to be submitted to the appropriate OWCP office within 10 working days after it is received from the employee.*

SEE 4.6, Reviewing the Information for Integrity.
4.7, Submitting the Claim Package to OWCP.

4.3 Processing Documentation — *ICCO*

☐ Date-stamp all claim documents upon receipt in the ICCO.

☐ Check the documentation to ensure receipt of the following:

— CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.*

— All medical evidence (Form 2491, *Medical Report — First-Aid Injuries*, and CA-17, *Duty Status Report,* and other documentation).

— The Employee Rights, Responsibilities, and Choice of Physician letter (see Exhibit 3.5b for sample) with the attachment Publication 71, *Notice for Employees Requesting Leave for Conditions Covered by the Family and Medical Leave Policies* (see Exhibit 3.5e).

— Form 3971, *Request for or Notification of Absence*, if required.

— Other information pertinent to the case (e.g., investigation report).

☐ Ensure that the data have been entered into the HRIS.

☐ Coordinate with safety personnel to ensure that Form 1769, *Accident Report*, has been completed.

4.4 Reviewing CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay* — *ICCO*

☐ Review CA-1 for completeness and accuracy. If it is incomplete, contact the employee, the employee's representative, or the employee's supervisor for the missing information.

☐ Any changes made on the Supervisor portion of the CA-1 must be initialed by ICCO personnel (or the supervisor) making the revision. If the employee wishes to make a change to the Employee Data portion, ensure that the employee initials the revision or submits the change in writing on a separate piece of paper that is signed and dated.

◇ *Under no circumstances may ICCO personnel revise any information submitted by the injured employee or by his or her representative or delay submission of the CA-1 to the OWCP within 10 working days from the date received by the supervisor.*

4.5 Reviewing the Medical Documentation to Assess the Duty Status — *ICCO*

Obligation: Assigning Limited Duty

When an employee is not totally disabled or has partially overcome the injury or disability, the USPS must make every effort to assign the employee to limited duty consistent with the employee's work limitation tolerance.

☐ Review the medical documentation, e.g., Form 2491, *Medical Report — First-Aid Injuries,* and CA-17, *Duty Status Report*, to ensure that it is sufficient to assess the employee's duty status and do the following:

— Determine if the medical documentation is consistent with the information reported on the claim form or other documentation.

Example: *If the severity and length of disability appears disproportionate to the injury (e.g., the CA-17 reflects 2 weeks of total disability for a finger contusion), ensure that the treating physician is aware of the availability of limited duty.*

— If the injured employee was seen by both an outside private physician and a USPS contract medical provider, determine if there is a conflict in medical opinion (see 6.6, Responding After the Fitness-For-Duty examination (FFD) Decision).

☐ If duty status has not been indicated, contact the treating physician, either in writing or by telephone, for clarification for ICCO to determine if a FFD is appropriate (ELM 547.3).

◇ *The ICCO or the control point may contact the treating physician concerning the employee's work limitations and restrictions imposed by the effects of the injury and possible job assignment. However, when possible, this contact should be made by either the health unit or USPS medical provider personnel. Contact with the treating physician for medical information other than the employee's duty status should be made only by the USPS associate area medical director, a medical provider, or the occupational health nurse administrator.*

SEE Chapter 6, Medical Management.

☐ If the employee's duty status has been indicated, do the following:

— If fit for full duty, (i.e., no disability, capable of working his or her regular job), determine if the employee is working. If the employee is back to regular work, no further follow-up is needed. If not, find out the reason.

— If fit for limited duty, (i.e., partially disabled, capable of working within his or her medical restrictions), determine if a proper limited duty job offer was made.

— Document any change in duty status. Immediately send a new CA-17 to the treating physician to formally document any change.

SEE Chapter 7, Limited Duty Program Management.

— If totally disabled (i.e., cannot work at all in any capacity), determine whether the employee elected COP on the CA-1, and if so, whether COP has been provided.

4.6 Reviewing the Information for Integrity — *ICCO*

☐ Using the information found in Exhibit 4.6, Conditions for Compensation of Claims, review the information to determine if there is a basis to challenge the claim or any part of it with OWCP, or any reason to refer the case to the Inspection Service for investigation of possible fraud or abuse.

SEE Exhibit 4.6, Conditions for Compensation of Claims.
Chapter 8, Controversion and Challenge.
Chapter 9, Fraud and Abuse.

4.7 Submitting the Claim Package to OWCP — *ICCO*

☐ Submit the employee's claim package to OWCP within the established 10-working-day time frame. If supportive information is available, submit the entire package consisting of the following:

- — A properly completed CA-1.
- — A properly completed CA-16.
- — All available medical documentation.
- — All supportive documentation (witness statements, investigation report, etc.).
- — The signed, dated copy of the Employee Rights, Responsibilities, and Choice of Physician letter (see Exhibit 3.5b for sample).

◇ *Do not, under any circumstances, delay submission of the CA-1. The 10-day period begins from the date of receipt by the postal official who initially receives the document. If medical reports and supportive information are not available, send a cover letter with the completed CA-1 advising OWCP what additional information will be forthcoming. This action will allow OWCP to assign a claim number and initiate the claims process.*

☐ The OWCP will notify the employee and the ICCO of the claim number by CA-801 (postcard). This information is also available on the Workers' Compensation Information Subsystem (WCIS). If this information is not available within 5 days after submission of the initial claim to OWCP, send available supportive information, making sure the DOI and Social Security number are included for identification.

◇ *Do not hold any information or documentation in suspense more than 5 days after submission of the initial claim to OWCP while waiting for a claim number to be assigned.*

Initial Occupational Illness or Disease Claims Management

When the ICCO receives notice of a potential occupational illness or disease...

4.8 Responding to Notice of a Potential Occupational Disease or Illness — *ICCO*

☐ Upon receipt of CA-2, *Notice of an Occupational Disease and Claim for Compensation,* inform the employee of the following:

- — COP is not applicable in cases of occupational disease or illness.
- — He or she is to submit CA-7 if he or she wishes to make a claim for compensation as a result of his or her job-related disease or illness or CA-8 if the disability continues and subsequent claims are to be made.
- — Compensation benefits (i.e., payment for lost wages, payment of medical expenditures, etc.) are contingent upon OWCP's approval of the claim. If approved, compensation is not payable for the first 3 days of disability unless the disability extends beyond 14 calendar days.
- — Medical care is authorized via CA-16 only with prior approval of OWCP.
- — Supporting medical and factual information as requested on the checklists, Forms CA 35A–H, will expedite OWCP's adjudication of the claim.

4.9 Reviewing CA-2, Notice of Occupational Disease and Claim for Compensation — *ICCO*

☐ Review the completed CA-2 for completeness and accuracy. If incomplete:

- Contact the employee, his or her representative, or the supervisor for the missing information.
- Assist the employee or supervisor in correcting any deficiencies.

☐ Insert the appropriate codes on both the front and back of the CA-2 in the following categories:

— Occupation.

— Type and source of injury.

— Agency code.

4.10 Reviewing the Claim Information for Integrity — *ICCO*

☐ Using the information found in Exhibit 4.6, Conditions for Compensation of Claims, review the information to determine if there is a basis to challenge the claim or any part of it with OWCP, or any reason to refer the case to the Inspection Service for investigation of possible fraud or abuse.

SEE Exhibit 4.6, Conditions for Compensation of Claims.
Chapter 8, Controversion and Challenge.
Chapter 9, Fraud and Abuse.

4.11 Submitting the Claim Package to OWCP or Retaining It — *ICCO*

☐ If medical expenses or lost time were incurred or are expected, submit the original completed CA-2 and accompanying documentation to the OWCP district office as soon as possible, but no later than 10 working days from when the form was received by the official supervisor.

◇ *Do not delay submission pending receipt of supportive and requested documentation.*

☐ If medical expense or lost time is not incurred or expected, submit the CA-2 to the district OWCP and file a copy of the CA-2 in the employee's OPF.

☐ Enter the claim and all other activity in HRIS to monitor the disability and OWCP's adjudication and establish call-up dates.

Claims Management in Case of Death

When the ICCO receives notice of a death from a traumatic injury or potentially from an occupational disease or illness...

Obligation: Informing Survivors of Compensation in Case of a Death

FECA provides for the payment of monetary compensation to specified survivors of an employee whose death is the result of an employment-related injury or illness and for payment of certain funeral and burial expenses.

4.12 Investigating a Death From a Traumatic Injury or Potentially From an Occupational Disease or Illness — *supervisor or ICCO*

☐ Immediately after receiving notice of an employee's death, notify the following individuals by telephone, telegram, or facsimile if available:

— Designated area HR analyst.

— The OWCP district office.

☐ Coordinate with safety personnel, the Inspection Service, local law enforcement personnel, or other investigative agencies to conduct a thorough investigation of the circumstances surrounding the employee's death.

The OHNA or the USPS contract medical provider should assist in making any necessary medical contacts (e.g., hospital emergency room, coroner's office) and securing their reports.

☐ IC personnel must prepare written notification on CA-6 and submit it to the OWCP as soon as possible, and within 10 working days of notification of the death.

4.13 Formally Notifying OWCP of the Death — *ICCO*

□ Upon completion of the investigation, initiate CA-6. Submit this form to OWCP as soon as possible and send a duplicate copy to the area HR manager via the designated area HR analyst. The statutory limits for filing these claims are:

— Within 10 working days after receiving knowledge of a death by traumatic injury.

— Within 30 calendar days after knowing, by the exercise of reasonable diligence, that the employee's death was due to an employment-related occupational disease or illness.

◇ *Failure on the part of the USPS to give written notice to OWCP within statutory time limits may result in a loss of compensation rights by the deceased employee's survivors in the event that the survivors fail to file a claim for compensation within 3 years.*

4.14 Contacting the Employee's Family — *supervisor or ICCO*

☐ Contact the employee's family, and do the following:

— Offer assistance in completing the appropriate claim form, i.e., CA-5, *Claim for Compensation by Widow, Widower, and/or Children*, or CA-5b, *Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.*

— Ensure that the employee's family is advised of their rights under FECA to collect payment of monetary compensation to specified survivors of an employee whose death is the result of an employment-related injury and for payment of certain funeral and burial expenses.

— Explain to the employee's family the distinction between OPM and OWCP benefits and arrange a meeting with the personnel services office for further explanation of OPM and OWCP entitlements.

☐ If the investigation reveals a basis to challenge the claim, prepare a challenge package in accordance with Chapter 8, Controversion and Challenge, and submit this to OWCP along with CA-5 or CA-5b.

◇ *Ensure that family contact is conducted in accordance with the local installation's established protocol.*

☐ If the employee's survivors are entitled to benefits, periodically review the case to ensure that the legal period of entitlement has not been exceeded.

Management of the 45-Day COP Entitlement Period

When the injured employee does not return to work immediately following a traumatic injury...

4.15 Responding to an Employee's Election of COP, Sick, or Annual Leave — *ICCO*

Obligation: Informing Injured Employees of Right to COP, Sick, or Annual Leave

A traumatically injured employee may elect to have COP for the first 45 calendar days of disability or to use sick or annual leave. This election must be made on the CA-1.

☐ Determine whether the employee has elected COP, sick, or annual leave on the CA-1.

☐ If the employee chooses sick or annual leave, ensure that the employee has been made aware of his or her rights and responsibilities (see Exhibit 3.5b, Sample Letter: Employee Rights, Responsibilities, and Choice of Physician).

☐ If the employee elects COP, follow the procedures in 4.16, Authorizing COP.

SEE Chapter 3, Immediate Involvement With Traumatic Injuries and Occupational Illnesses.

4.16 Providing COP — *ICCO or designated control point*

☐ Ensure that the supervisor has submitted the Form 3971, completed and signed with the CA-1 (see Exhibit 4.6).

☐ If the claim appears to satisfy the conditions for providing COP as shown in Exhibit 4.16, determine whether to:

— Provide COP. Prima facie medical evidence must be submitted within 10 working days for COP to continue.

— Provide COP but prepare to controvert it.

— Withhold COP and prepare to controvert it.

— Withhold COP and/or apply to OWCP for compensation.

◇ *COP may be controverted for any failure to meet conditions of entitlement. COP may be withheld, however, only in limited circumstances as specified in Exhibit 4-16. Remember that the final decision regarding COP entitlement rests with OWCP.*

SEE Exhibit 4.16, Conditions for Continuation of Pay, ELM 545.5.

☐ If the employee is entitled to COP, submit a completed and signed Form 3971. Enter the information into HRIS, and do the following:

— Review all available medical documentation to determine the estimated return-to-work (RTW) date.

— Track COP in segments corresponding with information cited on CA-17 or other documentation. Unless it is obvious from the beginning that the disability will be long term, never provide all 45 days of COP.

– If medical documentation is not initially available, provide COP for 10 working days or less. This will allow for receipt of prima facie medical evidence. If not received within this 10-day time frame, COP may be terminated; however, it must be reinstated upon receipt of the prima facie evidence.

– If medical documentation does not provide an anticipated RTW date, but continues to show total disability, use the next scheduled appointment date as a guide to track COP usage.

— Enter a call-up date in the HRIS to review COP and duty status that corresponds with the expiration of the latest COP period. This will help to avoid any unnecessary interruptions in the employee's pay.

— Update the COP tracking log in the employee's case file and determine the last day COP can be used and annotate the log.

◇ *Maintain close communication with the employee's supervisor or the control point regarding the employee's duty status to help prevent erroneous use of COP, unnecessary adjustments, and interruptions in the employee's pay.*

SEE Chapter 13, Timekeeping and Accounting.

☐ If COP entitlement is in question, determine what action to take.

SEE Chapter 8, Controversion and Challenge.

4.17 Monitoring the Medical Documentation to Determine the RTW Date — *ICCO*

- ☐ Closely monitor the supporting medical documentation, e.g., CA-17, to determine when the employee can return to work, in either a full or limited duty status.
- ☐ Check with OWCP to determine if medical information has been submitted directly to them.
- ☐ Contact the treating physician for an updated CA-17, if medical information is not available. (ELM 545.62)
- ☐ Initiate a FFD, if appropriate.
- ☐ Upon the employee's return, issue CA-3, *Report of Termination of Disability and/or Payment.*

  SEE Chapter 6, Medical Management.
- ☐ If it is anticipated that the employee's disability will extend beyond the 45-day COP entitlement period, issue CA-7, *Claim for Compensation on Account of Traumatic Injury or Occupational Disease*.

Continued Case Management

When it appears that an employee will remain totally or partially disabled beyond the first 45 days following a traumatic injury...

4.18 Monitoring a Partially Disabled Employee — *ICCO*

Assigning an Employee to Limited Duty

When an employee has partially overcome the injury or disability, the USPS must make every effort toward assigning the employee to limited duty consistent with the employee's work limitation tolerance.

- ☐ Assign the employee to a limited duty assignment, as specified in Section 7-4, Offering a Temporary Duty Assignment.
- ☐ Continue to monitor the medical documentation until the employee returns to full duty (see 4.5, Reviewing the Medical Documentation to Assess the Duty Status).
- ☐ If an employee files a CA-2a, *Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation*, see Chapter 5, Recurrence of Disability.

SEE Chapter 7, Limited Duty Program Management.

4.19 Initiating Compensation for a Totally Disabled Employee — *ICCO*

Obligation: Advising Employee of Obligation to Return to Work

The USPS must advise the employee of his or her obligation to return to work as soon as possible.

The USPS must advise the employee that pursuant to OWCP regulations, detailed supplementary reports must be made by the physician at approximately monthly intervals in all cases of serious injury or disease, including all cases requiring hospital treatment or prolonged care.

☐ When it appears likely that disability will extend beyond the COP period, provide the employee with CA-7 and the attached CA-20 at least 10 days before the end of COP and instruct him or her to complete Part A, items 1 through 20, on CA-7 and return it to the ICCO within 5 working days to preclude interruption of pay.

☐ Upon receipt of CA-7 from the employee:

— Complete CA-7, Part B, items 21 through 38.

— To ensure the continuation of health benefits, if the employee has been enrolled with health benefits since the first opportunity or for 5 years immediately preceding the start of injury compensation or from or before 12/31/64, note this fact in the “Remarks” section, showing the enrollment code and the beginning and ending dates of the pay period in which the employee’s normal pay ceased.

☐ Forward the completed CA-7 to the OWCP district office along with the completed CA-20 by the 40th calendar day of COP.

If the CA-20 has not been returned with the CA-7, submit the CA-7 to the OWCP and advise them that the employee has not returned the required medical documentation.

☐ Inform the employee of his or her rights and responsibilities (see Exhibit 4.19a, Employee Rights and Responsibilities in Extended Cases).

An employee who uses sick or annual leave after the 45-day COP period expires may be entitled to buy back sick leave with compensation payments (see Exhibit 4.19b, Sample Letter: Leave Buy Back Policy).

☐ Forward any subsequently completed CA-8 and any other accompanying medical reports to OWCP within 5 working days upon receipt from the employee.

SEE Chapter 13, Timekeeping and Accounting.

4.20 Initiating Actions for Continuing Health Benefits Enrollment — *ICCO*

☐ If the total period of disability is less than 29 days, no action needs to be taken on health benefits enrollment. When the total period of disability is more than 29 days in an LWOP-IOD status, coordinate with the personnel services office to ensure that necessary and appropriate actions are taken:

— If the employee is separated, contact OWCP to determine whether or not the enrollment can be transferred to OWCP.

– If enrollment can be transferred, OWCP will request transfer by letter (see Exhibit 4.20a, Sample Letter: Request for Transfer of Federal Employees Health Benefit (FEHB) Enrollment to OWCP). Send all Forms SF-2809, *Health Benefits Registration Form — Federal Employees Health Benefits Programs,* and SF-2810, *Federal Employees Health Benefits Program — Notice of Change in Health Benefits Enrollment,* and any other health benefits documentation in the employee's OPF to OWCP (see Exhibit 4.20b, Sample Letter: Transfer of FEHB Enrollment to OWCP).

– If OWCP does not request transfer for the employee who has been in LWOP-IOD status for 10 months, ICCO will coordinate with the personnel services office to send out a letter of transfer with supporting documentation to transfer health benefits enrollment to OWCP (see Exhibit 4.20b, Sample Letter: Transfer of Federal Employees Health Benefit Enrollment to OWCP).

– If enrollment cannot be transferred, terminate the enrollment.

— If the employee makes any permissible change in enrollment, notify OWCP by letter as soon as possible of the change and its effective date and file the letter in the IC file.

— If the enrollment has been transferred to OWCP and the employee subsequently is separated, notify OWCP by letter of the separation so that OWCP knows how to dispose of the enrollment if compensation payments cease.

Extended Claims Management

When the employee remains totally or partially disabled beyond 1 year...

4.21 Determining Whether an Employee Is Eligible to Participate in an In-House Rehabilitation Program — *ICCO*

Obligation: Reassigning an Employee Following Limited Duty

Limited duty is a temporary accommodation. If medical findings indicate that the employee has reached maximum medical improvement (MMI), he or she should either be returned to full duty or permanently reassigned to a modified position under the Rehabilitation Program.

□ When an employee has been working in a limited duty assignment for 1 year to determine whether the employee is eligible to participate in the USPS in-house rehabilitation program by reviewing the medical documentation.

□ If the medical documentation is not definitive, first check with OWCP to see if they have more current definitive medical information. If not, schedule the employee for an FFD. After the FFD is completed and an opinion rendered, do the following:

— If the medical evidence supports the employee's capability of performing full duty, submit a copy of the doctor's opinion letter along with all pertinent medical documentation to OWCP.

— If the medical evidence indicates the employee still has restrictions but further improvement is expected, continue the employee's limited duty assignment. Reevaluate in 6 months or the time frame specified by the examining physician for the anticipated improvement.

— If the employee's medical restrictions are deemed to be permanent by the examining physician, and such restrictions prevent the employee from ever returning to the employee's regular position, proceed with an in-house rehabilitation effort.

◇ *Conflicts in medical opinion must be ultimately resolved by OWCP before initiating any change in the employee's status. See 6.6, Responding After the FFD Decision.*

SEE Chapter 11, Rehabilitation Program
ELM 546

4.22 Determining Whether to Separate or Not to Separate an Employee After Remaining in an LWOP-IOD Status — *ICCO*

Obligation: Allowing LWOP-IOD Status for 1 Year

Disabled employees who receive OWCP compensation are placed in an LWOP-IOD status for an initial period of up to 1 year from the date OWCP compensation begins.

☐ At the end of the first year, determine whether to separate an employee from the USPS rolls by initiating the following actions:

— Permit the employee to remain in a LWOP-IOD status for an additional period to allow for a thorough review of the case.

— Request current claim status and copies of latest medical reports from OWCP.

— Schedule the employee for an FFD.

— If the medical documentation reflects that the employee is capable of performing full duty, do the following:

  – Ensure that any existing conflict in medical opinions are resolved by OWCP before initiating any other actions (see 6.6, Responding After the FFD Decision).

  – Direct the employee back to work by a letter that is signed by the district HR manager or designee and includes the following items:

    - The medical opinion as to duty status.
    - The report-to-duty date and time.
    - Where and to whom the employee should report.
    - A statement advising employee that failure to report may result in disciplinary action, including removal.
    - A description of job duties to include physical requirements of a job.

  – Forward a copy of the letter to the appropriate functional manager and forward all copies of correspondence along with all pertinent medical documentation to OWCP.

— If medical evidence supports temporary partial disability (i.e., the employee still has restrictions that prevent him or her from performing full duty), but further improvement is expected, issue a written limited duty job offer. Check with the treating physician to determine the period needed for medical improvement of the employee.

— If medical evidence supports permanent partial disability (i.e., the employee's restrictions are permanent, and he or she will never be able to perform full duty, but is capable of limited work), issue a written job offer for a permanent modified position under the provisions of the Joint DOL-USPS Rehabilitation Program (see Chapter 11, Rehabilitation Program).

— If medical evidence supports temporary total disability (i.e., the employee has not reached maximum improvement, but a return to work is expected), and if the anticipated return to work is expected within 6 months from date of examination, extend the LWOP-IOD status.

SEE Chapter 11, Rehabilitation Program.

☐ Reevaluate the employee's duty status at the end of the 6-month period.

— Initiate separation action when medical documentation supports permanent total disability, i.e., the employee will never be able to return to work in any capacity.

4.23 Separating an Employee in an LWOP-IOD Status From USPS Rolls — *ICCO*

☐ Prepare a request letter for separation action addressed to the manager of Safety and Risk Management at Headquarters, containing the following information:

— A brief history of the employee's injury.

— The date the employee entered into an LWOP-IOD status. The employee must have been in an LWOP-IOD status for 1 year before separation is requested.

— Conclusive medical reports that are no more than 6 months old and a summary of pertinent medical documentation substantiating the request for separation.

— A request to the area HR analyst for confirmation to terminate the employee's LWOP-IOD status and initiate separation action. The request is to be agreed with by the district HR manager and the appropriate functional manager and be signed by the district manager.

◇ *Submit your request directly to Headquarters unless your area ICCO has requested a review of the separation request before Headquarters' review.*

The employee must be maintained on USPS rolls until a formal decision is received from Headquarters.

☐ Upon concurrence with the manager of Safety and Risk Management at Headquarters, submit a memorandum to the personnel services office through the district HR manager that requests the local personnel services office to:

— Initiate employee notification and separation action.

— Advise the employee of his or her retirement rights in the notification letter.

Retirement Rights

If the employee is covered under the Civil Service Retirement System (CSRS) and has 5 or more years of creditable civilian service, he or she will be eligible to file an application for disability retirement under CSRS, provided the application is filed with OPM within 1 year from the date of separation from the Postal Service.

If the employee is covered under the Federal Employee's Retirement System (FERS), and has 18 months or more of creditable civilian service, he or she will be eligible to file an application for disability retirement under FERS, provided the application is filed with OPM within 1 year from the date of separation from the Postal Service.

If the employee is a noncareer employee, he or she must be advised to file with the Social Security Administration.

☐ Terminate the LWOP-IOD status and take appropriate separation action if the following are true:

— The employee does not file a retirement application within the 14-day period.

— The employee is covered under the CSRS and has less than 5 years creditable civilian service. (ELM 545.93)

— The employee is covered under FERS and has less than 18 months creditable civilian service.

☐ Enter a call-up into HRIS of 1 year to follow up with personnel services on status of separation action for review until compensation ceases. Ensure that HRIS is annotated when the employee has been separated.

◇ *Separation under these provisions does not preclude subsequent reemployment if medical status should change.*

4.24 Ensuring That Eligible Employees Receive Their Health Benefits Refund — *ICCO*

Obligation: Ensuring Refund of Health Benefits

The Health Benefits Refund Program is designed to reimburse injured employees for an overdeduction of health benefits premiums by the OWCP.

For the first year of compensable disability, OWCP deducts the employee portion of health benefits premiums at the USPS rate. Thereafter, the deduction is made at the standard rate applied by the OPM for federal employees. The OPM employee share of the premium cost is higher than the USPS employee share. Therefore, injured employees may be eligible for a refund for overdeduction of health benefits premiums.

☐ To determine that the employee is eligible for a refund, ensure that all of the following criteria are met for the period of compensable disability:

— The employee must be in an LWOP-IOD status. Employees who are separated from the USPS are not eligible for a health benefit refund.

— The employee must receive OWCP compensation payments with health benefits premiums deducted at the OPM rate.

— A period of at least 1 year must have elapsed since the employee was initially placed on OWCP compensation.

☐ Initiate Form 202, *Health Benefits Refund Payment Authorization*, and verify the information on the WCIS. Form 202 is initiated on a quarterly basis.

— Calculate amount of refund to be paid by subtracting the difference between the OPM health benefits premium rate and the Postal Service rate of the health benefits plan selected by the employee.

— Obtain approval on the completed Form 202 from the district HR manager or district manager.

— Forward Form 202 to the appropriate district finance office for payment using account identifier code (AIC) 587, *Fees for Service—Postal Operations.*

— File the original Form 202 in the employee's IC file and send one copy to the employee's OPF and two copies to the finance office.

In turn, the finance office will send the refund and a copy of Form 202 to the employee.

— Ensure that the injured employee has continuation of enrollment for health benefits.

4.25 Initiating Health Benefits Refund — *ICCO or designated control point personnel*

☐ To ensure that an eligible employee receives his or her health benefit refund:

- Initiate Form 202, *Health Benefits Refund Payment Authorization*, on a quarterly basis.
- In calculating the amount of the refund to be paid, subtract the difference between the OPM health benefits premium rate and the Postal Service rate of the health benefits plan chosen by the employee.
- Obtain approval of the facility manager or designee.
- Submit two copies of the refund authorization to the finance office for payment using AIC 587, Fees for Service — Postal Operations.
- File the original Form 202 in the employee's injury compensation file and one copy in the OPF.

The finance office will forward the refund and one copy of the Form 202 to the employee and retain one copy for its records.

Reassignment and Reemployment

When a current employee is to be reassigned or a former employee reemployed...

4.26 Considering a Former or Current Employee for Reemployment — *ICCO*

Obligation: Ensuring Reemployment or Reassignment of Employees Injured on Duty

Disability Fully Overcome Within 1 Year
When an employee fully overcomes the injury or disability within 1 year after the commencement of compensation payments from OWCP, or after compensable disability recurs, the USPS must give an employee the right to resume employment in the former or an equivalent position.

Disability Fully Overcome After More Than 1 Year
When a current or former employee fully overcomes the injury or disability more than 1 year after compensation begins, the USPS must give the current or former employee priority consideration for reemployment or reassignment into the former position or an equivalent one.

Disability Partially Overcome

— *Current Employee:* When an employee has partially overcome a compensable disability, the USPS must make every effort toward assigning the employee to limited duty consistent with the employee's medically defined work limitation tolerance. In assigning such limited duty, the USPS should minimize any adverse or disruptive impact on the employee.

— *Former Employee:* When a former employee has partially recovered from a compensable injury or disability, the USPS must make every effort toward reemployment consistent with medically defined work limitation tolerances. Such an employee may be returned to any position for which he or she is qualified, including a lower grade position than that which the employee held when compensation began.

☐ When an injured employee or former employee is being considered for reassignment or reemployment, ensure that postal obligations are met.

To ensure priority consideration of former employees who fully recover from their compensable disabilities more than 1 year after the start of compensation, enter their names on an employment list in two groups.

— Groups 1: All those entitled to 10-point veteran preference. They must be considered for employment before persons in Group 2.

— Groups 2: All other former employees. These former employees must be considered before other sources of recruitment, such as transfers from other agencies, reinstatements, or appointments from hiring registers.

— Current Employees. When an employee has partially overcome a compensable disability, the USPS must make every effort toward assigning the employee to limited duty consistent with the employee's medically defined work limitation tolerance (see 546.611). In assigning such limited duty, the USPS should minimize any adverse or disruptive impact on the employee.

SEE Chapter 11, Rehabilitation Program.

4.27 Ensuring Recognition of Appeal Rights — *ICCO*

Obligation: Ensuring Notification of Restoration Appeal Rights

OPM Appeal Rights

— Disability Fully Overcome Within 1 Year

An employee who has fully overcome the injury or disability within 1 year after the commencement of compensation payments from OWCP may appeal to the Merit Systems Protection Board (MSPB) if he or she believes a proposed offer of reemployment does not meet the requirements of restoration as outlined in he OPM regulations. The letter of appeal must be submitted within 30 days after the date of the offer or 30 days after the date of reemployment, whichever is later. (5 CFR 353.301)

— Disability Fully Overcome After More Than 1 Year

A current or former employee who fully overcomes the injury or disability more than 1 year after compensation begins may appeal to the MSPB only when he or she has requested restoration through formal application to the installation head and restoration has been refused. An appeal of the denial of restoration must be filed with MSPB within 30 days from the day the denial letter is received. Upon restoration, however, the injured worker is not given the right to appeal the nature of the restoration. (5 CFR 353.303)

— Disability Partially Overcome

A current or former employee who partially overcomes the injury or disability may appeal to the MSPB only when he or she has requested restoration through formal application to the installation head and restoration has been refused. The current or former employee may then appeal to the MSPB for a determination of whether the USPS is acting arbitrarily and capriciously in denying them restoration. (5 CFR 353.304 and 401)

FECA Appeal Rights

When the employee receives a written decision from OWCP, the employee will also receive a copy of his or her appeal rights (as outlined in Chapter 8, Controversion and Challenge). The employee is advised to read the information carefully and to specify clearly which one of the procedures he or she is requesting in appealing a decision.

☐ When an injured current or former employee is entitled to restoration rights upon return to work but believes he or she has not received proper consideration for restoration or has been improperly restored, ensure that the current or former employee understands his or her right to appeal to the MSPB under CFR 353.

Exhibit 4.6

Conditions for Compensation of Claims

For a claim to be compensable under FECA, it must satisfy five basic conditions.

Time

The claim must be filed within the statutory time limits as follows:

— Written notice of injury or death must be filed within 30 days after the occurrence of the injury or death (a timely claim for compensation also constitutes a timely notice of injury).

— The original claim for disability or death compensation must be filed within 3 years after the occurrence of injury or death, although allowances will be made in the following cases:

  – The USPS had actual knowledge of the injury or death within 30 days after occurrence, acquired from the immediate supervisor's firsthand observation, from another employee, from USPS medical personnel, from an entry into the employee's OMF, or from results of tests conducted by the ICCO in connection with known occupational hazards.

  – Written notice of injury or death was given within 30 days of its occurrence.

Normally, timeliness is not a factor when challenging entitlement to compensation benefits. It is rare that the 3-year time frame cited above is exceeded. However, timeliness is frequently a basis for controverting and withholding COP. It is not uncommon for an employee to exceed the 30-day requirement for filing written notice of injury. (ELM 544.212)

If the claim was not filed within the time limits given, contact the OWCP district office. OWCP may excuse late notice of injury or death if exceptional circumstances exist.

These time limits apply only to injuries and deaths that occurred on or after 9/7/74. Contact OWCP regarding injuries that occurred before this date.

Postal Service Employee

The injured employee or decedent must be or have been an employee of the USPS at time of injury or exposure, regardless of the length of time on the job or the type of position held (including casual and transitional).

Occasionally, a question will arise as to whether an injured worker has "employee" status under FECA. This usually occurs in cases involving contract drivers or contract cleaners. OWCP will determine this factor using any of the following criteria:

— Whether the worker performed services or offered services to the public generally as a contractor, or was permitted to do so by the USPS.

— Whether the worker was required to furnish any tool or equipment.

— The period of time the work relationship was to exist.

— Whether the USPS had the right to discharge the worker at any time and, if so, when and under what circumstances.

— Whether the USPS had any right to control or direct the manner in which the work was performed.

— The manner in which payment for the worker's services was determined.

— Whether the activity that the worker was engaged in was a regular and continuing activity of the USPS.

Fact of Injury

The employee or decedent must have sustained an injury as defined in FECA.

The following issues must be addressed:

— Whether the alleged incident or exposure actually happened.

— Whether the alleged incident or exposure happened in the manner cited by the employee.

Example: A clerk alleged injury to the left side of her body when she slipped on water in a rest room. However, an eyewitness stated that when she walked into the rest room, she found the claimant sitting on an ashtray, asleep. When the eyewitness awoke the claimant, she became startled and collapsed to the floor as she attempted to stand up. The eyewitness further stated that there was no water on the rest room floor, and the claimant noted that her legs were numb.

In order to establish a fact of injury in a traumatic case, the employee has to establish that the injury occurred while in the performance of duty in the time, place, and manner alleged, and that the injury resulted from a specific event or incident. An injury does not have to be confirmed by an eyewitness in order to establish the fact that an employee sustained an injury in the performance of duty, but the employee's statement must be consistent with the surrounding facts and circumstances and subsequent cause of action.

Performance of Duty

The injury, illness, or death must have resulted from an incident or circumstance occurring while the employee was performing official duties.

The injury, illness, or death must have resulted from one or more of the following situations:

— The employee's performance of regular or special assigned duties, including activities considered reasonable incidents of employment (e.g., established coffee breaks).

— A requirement imposed by the employment.

— An employee's fear and anxiety regarding his or her ability to carry out official duties.

Injuries resulting from employment matters other than those cited above are generally regarded as not arising out of, or in the course of employment and, therefore, are not covered by FECA. In some cases, however, it is difficult to define the "performance of duty" factor, so it is imperative that the ICCO investigation be thorough and accurate.

Example: A carrier was injured in a vehicle accident while delivering his or her assigned route. The initial information received stated that the carrier was assigned to a foot route, did not have a drive-out agreement, and utilized his or her private vehicle without authorization. Based on this initial information, it appeared that the carrier's actions removed him or her from the scope of his or her regular assigned duties and, in turn, provided a basis to challenge the claim.

A further investigation, however, revealed that the use of private vehicles (without drive-out agreements) was common practice at the employee's station, and in fact many carriers also used private vehicles without a drive-out agreement with the full knowledge of their supervisor. The fact that management was aware and obviously condoned this practice placed it in the realm of regular assigned duties and made it a compensable employment factor.

Causal Relationship

The injury, disability or death must be caused by conditions of employment.

Causal relationships are medical issues and must be supported by medical documentation provided by a recognized physician.

Four types of causal relationships are recognized:

— *Direct causation* — when the injury or factors of employment, through a natural and unbroken sequence, result in the claimed condition.

Example: As a result of a slip and fall on ice, a carrier fractures his arm.

— *Aggravation* — when a preexisting condition is worsened, either temporarily or permanently, by an injury arising in the course of employment. Compensation is payable for the duration of the aggravation as medically determined.

Example: A mail handler's preexisting degenerative disc disease is aggravated when the gate of an all-purpose container falls on him.

– *Temporary aggravation* — a limited period of medical treatment or disability until the employee returns to his or her pre-injury physical status. Compensation is payable only for the period of aggravation established by the weight of the medical evidence, and not for any disability caused solely by the underlying disease.

- *Permanent aggravation* — when a condition persists indefinitely because of the effects of the job-related injury or when a condition is materially worsened such that it will not revert to its pre-injury level of severity.

— *Acceleration* — when a job-related injury or disease hastens the development of an underlying condition and the ordinary progression of the disease would not account for the speed with which a condition develops.

Example: An employee's diabetes may be accelerated by a work schedule so erratic that it prohibits the regular intake of food required by persons with this condition.

— *Precipitation* — when a latent condition manifests itself because of factors of employment. As with aggravation, precipitation may be either temporary or permanent.

Example: A custodian with tuberculosis, latent for a number of years, has renewed exposure in the workplace. In this case, the acceptance of the claim is limited to how long the work-related tuberculosis lasts. Entitlement to compensation ends once the person recovers.

Exhibit 4.16
Conditions for Continuation of Pay

Providing COP

An injured employee's request for COP must be granted by the USPS except in the following six circumstances:

— The disability is caused by an occupational disease.

— The injury occurs off USPS premises and the employee is not performing official "off premise" duties.

Example: Employee comes into the post office to pick up paycheck on scheduled day off; changing a tire in the parking lot located on postal premises.

— The injury is caused by one of the following:

  – The employee's willful misconduct.

  – The employee's intent to kill or injure himself or herself or another person.

  – The employee's intoxication by alcohol or illegal drugs.

— The injury is not reported on CA-1 within 30 days following the injury.

— Work stoppage first occurred more than 90 days following the injury.

— The employee initially reports the injury after his or her employment has terminated.

When casual employees or other employees with specific terms of employment are injured, provide COP only through the end of their appointments.

The USPS may controvert the employee's right to COP for reasons other than the six circumstances cited above. However, the final determination of COP entitlement lies with OWCP.

Withholding and Terminating COP

The ICCO is responsible for challenging a claimant's case if it is found that the five basic conditions have not been met and for controverting COP to which the claimant is not entitled. COP may also be withheld or terminated during the 45-day COP period only in those cases meeting the criteria specified in FECA's implementing regulations. In questionable cases, contact the area HR analyst for guidance. Ensure that the USPS is in compliance with FECA.

Do *not* withhold or terminate COP in the following situations:

— As part of disciplinary action, or as a result of a disciplinary action that terminates employment, unless written notice of termination for cause was issued to the employee before the date of injury.

— Pending OWCP's controversion decision.

— In cases when either one of the following applies:

- Facts of injury are questionable.
- Medical evidence does not establish causal relationship.

Immediately notify the employee if COP is either withheld or terminated.

Controverting and Withholding COP

Controvert and withhold COP in the following situations:

— The injured worker was not a USPS employee at the time of the injury or exposure.

— The injury or exposure did not occur on USPS premises and the employee was not in the performance of duty.

— The injury is proximately caused by one of the following:

- The employee's willful misconduct.
- The employee's intent to bring about injury or death to himself or herself or another person.
- The employee's intoxication by alcohol or illegal drugs.

— The employee suffers an occupational illness rather than a job-related traumatic injury. In this case, the employee may apply for compensation or take annual or sick leave.

— The employee files the CA-1 more than 30 days from the date of injury.

— The employee files the CA-1 after the termination of employment.

— Work stoppage occurs more than 90 days after the date of the injury.

In cases where timeliness of filing is at issue, contact OWCP. Allowances are sometimes made for unusual circumstances.

Terminating COP

Terminate COP in the following situations:

— The employee does not submit prima facie medical evidence within 10 working days after claiming COP. In this case, ensure that the employee is aware of this requirement and of the fact that COP may be reinstated upon receipt of such evidence.

— The ICCO receives medical evidence that the employee's treating physician has found the employee to be no longer disabled, but capable of performing the duties of the position held at the time of injury. In this case, direct the employee back to work.

— The ICCO receives medical evidence that the employee's treating physician has found the employee to be partially disabled and the employee does not respond to a written limited duty assignment offer within 5 working days of such offer.

— The ICCO receives notification from OWCP that COP should be terminated.

— The employee's scheduled period of employment expires or employment is otherwise terminated, provided the date of termination of employment was established before the date of injury.

Exhibit 4.19a

Employee Rights and Responsibilities in Extended Cases

When an employee remains totally or partially disabled beyond the first 45 days following a traumatic injury, he or she must be advised of the following rights and responsibilities:

— He or she is obligated to return to work as soon as possible.

— He or she has the right to file a claim for compensation on CA-7.

— He or she is responsible for having the treating physician complete the attached CA-20, *Attending Physician's Report*, in duplicate, and forward the original to OWCP and the duplicate to the ICCO (enclose an official postage-paid return envelope).

— OWCP compensation may be used after the 45-day COP expires but there is a waiting period of 3 calendar days before compensation begins. This period begins immediately after the end of the 45-calendar day COP period, may not be satisfied by using sick or annual leave, and must be a nonpay status.

— If the disability continues for more than 14 calendar days after the expiration of the 45-day COP period, then the 3-calendar-day waiting period is no longer applicable.

— He or she may be entitled to buy back leave used with compensation payments.*

— If disability extends beyond the period claimed on CA-7, subsequent claims are submitted on CA-8, *Claim for Continuing Compensation on Account of Disability*.

— He or she is responsible for submitting or arranging for the submission of medical evidence in support of the claim. CA-20a, *Attending Physician's Supplement Report,* is attached to CA-8 for this purpose.

— He or she must complete CA-8, items 1 through14, and forward it to the ICCO for completion of items 15 through 24.

— He or she must file CA-8 every two weeks during the period of disability unless otherwise instructed by OWCP.

* Employees on USPS rolls may buy back leave. Employees on the rolls must be advised, in writing, by the ICCO or control point following their return to duty that the buy back must be initiated within 1 year of the return or within 1 year of the date OWCP approved the claim, whichever is later. Employees who are being separated because of disability or other reasons must be advised, in writing, before separation that they cannot buy back leave after they are off the rolls.

SEE Exhibit 4.19b, Sample Letter: Leave Buy Back Policy.

Exhibit 4.19b

Sample Letter: Leave Buy Back Policy

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Leave Buy Back Policy
To:

File Number: ___[OWCP case number]_____

Date of Injury: ___[date]____

This refers to your job-related injury or illness of ___[date]___ and the annual or sick leave used during the period ___[dates]___.

A claim for compensation ___[was/will be]___ submitted to the Office of Workers' Compensation Programs (OWCP) for the above leave period. If the OWCP approves this claim, you may be entitled to buy back the leave with compensation payments.

Please be aware that you will not be permitted to buy back leave unless the buy back is initiated within the prescribed time frame and you are on the rolls of the Postal Service.

If you intend to buy back leave, the buy back must be initiated within 1 year following your return to duty or within 1 year of the date OWCP approved your claim, whichever is later. Moreover, only current employees (i.e., employees on the rolls of the Postal Service) may buy back leave. Therefore, if you are separated from the Postal Service because of disability, retirement disability, or other reasons, you cannot buy back leave after you are off the rolls.

If you have any questions, please contact either the Injury Compensation Control Office at ___[telephone number]___ or OWCP.

We are available for guidance and assistance and will be happy to answer your questions.

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: Employee's IC File
OWCP

Exhibit 4.20a

Sample Letter: Request for Transfer of FEHB Enrollment to OWCP

U.S. Department of Labor

Employment Standard Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation
Washington, DC 20210

Request for Transfer of FEHB Enrollment to OWCP

Employing office name and address:

Date of request:
File number:
Employee's name:
Social Security number:
Effective date of transfer:

The above-named employee is receiving compensation under the Federal Employee's Compensation Act and we are withholding premiums for the employee's Federal Employees Health Benefits (FEHB) Program enrollment from the employee's compensation.

Please forward the employee's health benefits enrollment documents to this office as specified in the Federal Employees Health Benefits Handbook (formerly the Supplement 8901 of the Federal Employee's Personnel Manual). The documents include the copies of every SF 2809 and SF 2810 in the employee's Official Personnel Folder beginning with the date of his or her initial enrollment in the FEHB Program, together with any related documentation (such as medical documentation from a disabled child over age 22). As of the effective date shown above, OWCP is the employing office for this employee.

If you have sent the employee's OPF to the Federal Records Center, it is your responsibility to recall it so that you can comply with this request.

If you have any questions concerning this request, you may contact:

Name of contact:
Telephone number:

To be completed by employing office

Employing office: Attach documents to this form and return to OWCP. File a copy of the form in the employee's OPF to show the disposition of the FEHB documents.

Name of employing office contact	Telephone number	Date documents sent to OWCP

U.S. G.P.O.: 1994–3B7–360:1414.20b

Exhibit 4.20b

Sample Letter: Transfer of Federal Employees Health Benefit Enrollment to Office of Workers' Compensation Programs

[U.S. Postal Service Letterhead]

___[date]___
___[name of OWCP district office]___
___[street address]_____
___[city, state, ZIP Code]___

Date of request:
OWCP file number:
Employee's name:
Social Security number:
Effective date of transfer:

The above-named employee is receiving compensation under the Federal Employee's Compensation Act (FECA), and Office of Workers' Compensation Programs (OWCP) is withholding premiums for the employee's Federal Employees Health Benefits (FEHB) Program enrollment from the employee's compensation.

Attached are the employee's health benefits enrollment documents, which this agency is forwarding to OWCP as specified in the *Federal Employees Health Benefits (FEHB) Handbook* (formerly the Supplement 890-1 of the *Federal Employees Personnel Manual*). The documents include the copies of every SF-2809 and SF-2810 in the employee's official personnel folder (OPF) beginning with the date of his or her initial enrollment in the FEHB Program, together with any related documentation (such as medical documentation for a disabled child over age 22). As of the effective date shown above, OWCP is the employing office for this employee.

The reason for this action is:

[ ] This employee is separating (or has separated on) ___[date]___ .

[ ] This employee will complete 365 days in nonpay status on ___[date]___ .

If you have any questions concerning this transfer, you may contact:

___[name of contact]___
___[telephone number]___

Sincerely,

___[signature of personnel official]_____

5. Recurrence of Disability

Overview

Procedures

Report of Recurrence to Supervisor

When an employee is again disabled as a result of the original compensable injury or illness...

5.1 Identifying a Recurrence of Disability . . . . . *supervisor*
Obligation: Initiating a Claim in Case of Recurrence
5.2 Initiating Claim Forms . . . . . *supervisor*

Notice of Recurrence to ICCO

When the ICCO receives notice of an employee's recurrence of disability...

5.3 Responding to Notice of a Recurrence of Disability . . . . . *ICCO*
Obligation: Processing a Recurrence Claim

Notice of Return to Work

When an Employee Returns to Work...

5.4 Notifying OWCP of Employee's Return to Work . . . . . *ICCO*

Exhibits

5.1 New Injuries and Illnesses vs. Recurrences

5. Recurrence of Disability

Overview

This chapter addresses the roles of the supervisor, control point, and ICCO when an employee experiences a recurrence of disability from a job-related traumatic injury or occupational illness or disease.

Care must be taken to differentiate a true recurrence of a disability, a disability caused by a new injury or illness, or a compensable condition related to a previous disabling injury or illness so that the proper procedure can be followed. Supervisors and IC personnel must remain alert to whether there is an "intervening cause" that may signal the occurrence of a new injury and whether that intervening cause occurs on or off duty.

A disability resulting from a job-related incident or incidents identifiable in time and place is considered a new injury or illness. The term "recurrence" is reserved for a spontaneous return or increase of disability without an intervening cause. This chapter addresses these distinctions and provides examples that will help in making the differentiation.

Procedures

Report of Recurrence to Supervisor

When an employee is again disabled as a result of the original compensable injury or illness...

5.1 Identifying a Recurrence of Disability — *supervisor*

Obligation: Initiating a Claim in Case of Recurrence

The employee must immediately notify his or her supervisor of the recurrence of disability.

The supervisor must immediately initiate CA-2a, *Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation*.

☐ Discuss the situation with the employee when he or she reports a recurrence of disability. With the help of Exhibit 5.1, determine if a recurrence of disability, a new injury or illness, or a related compensable condition exists (see Exhibit 5.1, New Injuries and Illnesses vs. Recurrences).

☐ Prepare to controvert or challenge any element of the recurrence of disability not deserving a specific benefit.

◇ *Contact the area HR analyst or the OWCP district office to request instructions in any case where there may be doubt that the symptoms or disability are the result of the initial injury.*

5.2 Initiating Claim Forms — *supervisor*

☐ If the injury or illness is *new,* provide the employee with either CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, or CA-2, *Notice of Occupational Disease and Claim for Compensation*, and follow directions for processing as outlined in Chapter 4, Claims Management.

☐ If the injury or illness is *consequential* or *intervening*, provide the employee with either CA-7, *Claim for Compensation on Account of Traumatic Injury or Occupational Disease*, or CA-8, *Claim for Continuing Compensation on Account of Disability*; write a letter of explanation to OWCP if necessary; and follow directions for processing as outlined in Chapter 4, Claims Management.

☐ If the injury or illness is a *recurrence* of disability, initiate the following steps:

— Provide the employee with CA-2a.

— Instruct the employee to do the following, requesting the ICCO for assistance as necessary:

  – Read the "Instruction for Employee" portion on CA-2a.
  – Complete the CA-2a, Part-A, items 1 through 23.
  – Submit all factual and medical evidence in support of the determination of recurrence of disability.
  – Promptly return the completed CA-2a.

— Review the employee's completed portion of CA-2a and complete Part B, items 24 through 44.

— Immediately forward the completed CA-2a, along with any attachments or statements, to the ICCO or the designated control point.

☐ Issue CA-16, *Authorization for Examination and/or Treatment,* to authorize examination or treatment for the recurrence of disability provided:

— The claim is for an injury, not an illness.

— OWCP has not disallowed the original claim.

— More than 6 months have not elapsed since the employee last returned to work.

In those situations when the USPS cannot authorize the examination and treatment, contact the ICCO so that IC personnel can contact the OWCP district office for the employee to obtain authorization.

Notice of Recurrence to ICCO

When the ICCO receives notice of an employee's recurrence of disability...

5.3 Responding to Notice of a Recurrence of Disability — *ICCO*

Obligation: Processing a Recurrence Claim

If, after having been discharged from medical treatment, an injured employee again has symptoms or disability under circumstances from which it may reasonably be inferred that the symptoms or disability are due to an injury previously recognized as compensable by OWCP, the ICCO authorizes the required medical care, if applicable; provides COP, if applicable; and informs the employee of compensation entitlement if COP is exhausted or the period of COP entitlement has expired.

☐ Upon receiving CA-2a, review the form for completeness and accuracy and complete Part B, items 24 through 44, if the employee's supervisor has not already done so. If the form is incomplete, contact the employee or his or her representative for the missing information and assist the employee or representative in correcting any deficiencies found.

☐ Authorize medical care by using CA-16 if the supervisor has not done so.

In those situations when the USPS cannot authorize the examination and treatment, contact the OWCP district office for the employee to obtain authorization.

☐ Provide COP up to the amount of any remaining COP, if all the following conditions are met:

- — Recurrence of disability stems from a traumatic injury, not an occupational disease or illness.
- — The original claim of disability has not been denied by OWCP.
- — The 45-day COP period has not been exhausted.
- — The disability recurs within 90 days of the date the employee first returns to work following the initial period of disability.

☐ Obtain periodic medical evidence on CA-17, *Duty Status Report,* in cases where pay is continued.

☐ Inform the employee that he or she must initiate a claim for compensation on CA-7 if any of the following conditions are met:

- — Recurrence of disability stems from an occupational illness or disease.
- — The 45-day COP period has been exhausted.
- — Disability recurs more than 90 days after he or she first returns to work.

☐ If CA-7 has previously been submitted, instruct the employee to file the claim on CA-8.

☐ Submit the original completed CA-2a and accompanying forms and documentation, if any, to the OWCP district office as soon as possible. If there is a lost time workday, make a copy of the CA-2a for the IC claim file and a copy for Safety.

◇ *Never delay submission of the CA-2a to OWCP pending receipt of medical report and documentation.*

☐ Prepare to controvert or challenge any element of the recurrence of disability not deserving a specific benefit.

◇ *Contact the area HR analyst or the OWCP district office to request instructions in any case where there may be doubt that the symptoms or disability are the result of the injury.*

Notice of Return to Work

When an employee returns to work...

5.4 Notifying OWCP of Employee's Return to Work — *ICCO*

☐ The employee may have returned to work by the time CA-2a is submitted to OWCP. If so, no notice of return to work is required. If not, when the employee *does* return to work, complete and forward CA-3, *Report of Termination of Disability and/or Payment*, to the OWCP.

Exhibit 5.1

New Injuries and Illnesses vs. Recurrences

Distinguishing Between New Event and Recurrence

Confusion in distinguishing a recurrence of disability from a new injury or illness occurs when physicians relate symptoms back to an old injury without considering whether there is an intervening cause or whether it occurs on or off duty. The same is true when a previous condition is exacerbated by an occupational disease.

New Injury or Illness

If, while the employee is in the performance of duty, a second incident occurs and precipitates an injury, even if the injury is to the same part of the body previously injured, it is considered a new injury. If a new exposure to the same causes again precipitates an occupational disease or illness, it is considered a new illness. Both result from a circumstance that is considered an *intervening cause* that occurs *during the performance of duty.*

Because compensable conditions include aggravations and accelerations of preexisting or underlying conditions, aggravation of a previous injury may be diagnosed as a new traumatic injury. The definition applies without consideration of the length of time since the last injury. For instance, an employee may have bona fide back injuries on 2 consecutive days.

A condition from a previous injury may be aggravated by stress or strain in the work environment. This condition constitutes a new occupational disease.

A new injury is reported on CA-1; a new illness on CA-2.

Define or refer to traumatic injury and occupational disease as:

— Traumatic injury means a wound or other condition of the body caused by external force, including stress or strain. The injury:
  – Must be identifiable as to time and place of occurrence and member or function of the body affected.
  – Must be caused by a specific event or incident, or series of events or incidents, within a single day or work shift.
  – May also include damage to or destruction of prosthetic devices or appliances.
— Occupational illness or disease means an illness or disease produced by one of the following:
  – Systemic infections.
  – Continued or repeated stress or strain.
  – Exposure to toxins, poisons, fumes, etc.
  – Other continued and repeated exposure to conditions of the work environment over a longer period of time than a single day or work shift.

Related Compensable Conditions

Two other kinds of injury or illness are compensable because of their relationship to a previous job-related injury or illness. Although there is an intervening cause, it *does not occur while the employee is in the performance of duty*.

— A *consequential injury* is an injury that occurs outside the performance of duty but is considered to be the result of a job-related injury or a weakness or impairment caused by a work-related injury. Included in this definition are injuries caused by weakness from or treatment for an accepted job-related injury.

Example: Crutches prescribed for an on-the-job ankle injury cause a shoulder condition. The shoulder condition is a consequential injury because, although it occurred during nonwork hours, it resulted from impairment caused by a work-related injury.

— An *intervening injury* is an injury that occurs outside the performance of duty to the same part of the body originally injured and is considered to be at least partially the result of the original job-related injury rather than the result of the second injury alone. The resulting condition is considered related to the original injury unless the second injury alone is established as its cause.

There is no designated form to advise OWCP of a consequential or intervening injury. A CA-7 or CA-8 is used if necessary to request compensation.

Example: An employee sustained a job-related injury to his left knee and began receiving compensation benefits. He underwent vocational rehabilitation and returned to a suitable job. He later filed a claim for recurrence of disability when he reinjured the left knee while playing basketball. In view of his left knee condition, playing basketball was not a reasonable activity, and the recurrence of disability filed was not the result of the natural consequence or progression of his job-related injury but was due to an independent, *intervening* cause attributable to his own intentional conduct (ECAB Decision No. 90–0594, issued 11/16/90).

Recurrence

A *recurrence of disability* is a spontaneous return or increase of disability because of a previous injury or occupational disease without intervening cause.

A CA-2a is used to report a recurrence of injury or illness.

Selecting the Appropriate Form

Sample Case #1

A window clerk sustains a sprained right ankle from tripping on a mail sack. After a brief period of disability and physical therapy, she returns to her regular duties, which are sedentary. Following her return to work, she is selected for a letter carrier position requiring long periods of standing and walking. She had applied

for the position before her ankle injury. After 3 months as a letter carrier, the employee complains of ankle pain and submits medical evidence certifying that she is disabled for the letter carrier job. The medical report states that the prolonged walking has aggravated the employee's weakened ankle. What form, if any, is needed at this time?

Answer: This employee would need to file CA-2, *Notice of Occupational Disease and Claim for Compensation.* She has identified the repeated stress and strain of walking as the source of her current disability. The claimant needs to submit medical and factual evidence in support of her claim.

Sample Case #2

A secretary with the USPS is currently performing limited duty as the result of a back injury suffered on the job 2 weeks ago. While he is typing at his desk, he is jarred by a mail cart hitting his chair. His previously moderate back pain is suddenly unbearable. He leaves work immediately to return to the physician who has been treating him. Should he file another claim form?

Answer: In this situation, the employee has sustained a new injury. He can associate the onset of pain with a specific event identifiable by time and place of occurrence within one work shift or workday. This applies even though he was only released to limited duty and is still under treatment. Accordingly, he should file CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation,* and is entitled to another 45 days of COP for any time lost.

Sample Case #3

A postal inspector is confined to desk work after sustaining a low back injury during a scuffle with a suspect. She is receiving physical therapy three times a week. On Monday morning, she calls in sick saying that she lifted her small daughter over the weekend and exacerbated her back pain. What should she do now?

Answer: This employee appears to have sustained an intervening injury. This is an injury that occurs outside the performance of duty to the same part of the body originally injured. The resulting condition is considered related to the original injury unless the second injury alone is established as its cause. Because the inspector is still under active medical treatment and has only been released to limited duties, it is unlikely that the second injury alone is enough to cause her current disability. There is no form designed to advise OWCP of an intervening injury. This employee should simply inform OWCP of the second incident by letter. She should also submit a medical report that includes an opinion on the relationship between disability and the original injury. If her eligibility for COP has expired, she will also need to file CA-7, *Claim for Compensation on Account of Traumatic Injury or Occupational Disease.*

Sample Case #4

An occupational health nurse with the USPS has been performing modified work since sustaining a wrist injury 6 months ago. The physical demands of his modified work are very light; however, he has made frequent complaints of wrist pain to his supervisor. Despite the complaints, the employee has not seen his treating physician since returning to work 4 months ago. Late on a Thursday afternoon, he says he cannot take the pain any longer and is going to his physician. The following day, he reports to his supervisor that the doctor has taken him off work and is recommending surgery. The doctor feels the current problems are related to the original injury. What is required of the employee?

Answer: The employee seems to have had a recurrence of disability. He should be requested to file a CA-2a, *Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation*; supporting documentation; and CA-7, *Claim for Compensation on Account of Traumatic Injury or Occupational Disease*, for lost time.

6. Medical Management

Overview

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Medical Evidence

When determining an injured employee's duty status...

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Fitness-for-Duty Examination

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6.8 Processing Medical Bills . . . . . *ICCO*
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Exhibits

6.1 Sample Letter: Limited Duty Availability

6.2a Medical Management Tools
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6.2b Sample Letter: Referral Consideration for the Nurse Intervention Program

6.4 Sample Letter: Employee Fitness-for-Duty Examination Scheduling

6.5a Sample Letter: Board-Certified Specialist Fitness-for-Duty Examination Consultation Scheduling

6.5b Sample Letter: Employee Fitness-for-Duty Examination Consultation Scheduling

6. Medical Management

Overview

This chapter addresses basic medical management procedures, as well as various services and medical management tools available to assist the ICCO. Effective medical management from the onset of the injury or illness is the key to returning injured employees to work as soon as possible.

The first section of the chapter illustrates situations and responses encountered when managing medical claims. The second section details what medical bills may be submitted for payment and what steps to take for processing.

The chapter is primarily written for ICCO personnel; however, a few sections pertain to the responses of the OHNA when tracking occupational injuries and illnesses.

Procedures

Medical Evidence

When determining an injured employee's duty status...

Obligation: Requesting Medical Examinations

The USPS has the authority to require the employee to undergo a medical examination to determine whether the employee meets the mandatory medical requirements of the position held or is able to perform the duties of that position. This examination cannot, however, interfere with issuance of CA-16, with the employee's free choice of physician, or with any authorized examination or treatment. (ELM 545.2, Authorizing Examination and/or Treatment, and ELM 543.1, Initial Medical Examination and/or Treatment. For emergency treatment, refer to ELM 545.24.)

6.1 Ensuring That Medical Evidence Substantiates the Injured Employee's Duty Status — *ICCO*

Obligation: Securing the Treating Physician's Duty Status Statement

The physician or hospital must, for each visit of the employee, make a professional statement showing that the employee is one of the following: *fit for duty*; *fit for limited duty*, with the work tolerance limitations indicated; or *not fit for duty*, with an expected return-to-duty date indicated.

☐ Inform the employee that his or her physician or hospital must, for each visit, make a professional statement showing that the employee is one of the following:

— Fit for duty.

— Fit for limited duty, with the work tolerance limitations indicated.

— Not fit for duty, with an expected return-to-duty date indicated.

Injury Beyond First Aid

When the injury requires more than two visits, it is no longer considered a first-aid injury, and Form 2491 may no longer be used. When the injury goes beyond first aid (third visit) and the criteria set forth in Chapter 3, Immediate Involvement With Traumatic Injuries and Occupational Illnesses, are met, CA-16 is issued.

☐ Instruct the employee to advise the physician that limited duty is available. Have the employee provide the treating physician with all the appropriate medical forms for all visits to the treating physician subsequent to the initial visit.

— If the employee elects treatment by a USPS contract medical provider, issue the following forms:
  – For a first-aid injury, provide Form 2491, *Medical Report — First-Aid Injuries*. This form is used for the follow-up visit as well as the initial visit.
  – For treatment beyond first aid, provide the following forms:
    - CA-16, *Authorization for Examination and/or Treatment*.
    - CA-17, *Duty Status Report.*
    - HCFA-1500, *Health Insurance Claim Form* (billing).

— If the employee elects treatment by a private physician, provide the following forms:
  – CA-16, *Authorization for Examination and/or Treatment* (required by 20 CFR 10.402a for traumatic injuries).
  – CA-17, *Duty Status Report*.
  – CA-20, *Attending Physician's Report.*
  – HCFA-1500, *Health Insurance Claim Form* (billing).

☐ When medical reports do not reflect duty status, contact the treating physician to clarify the employee's availability for either full or limited duty, and follow up with a letter with an enclosed CA-17 (see Exhibit 6.1, Sample letter: Limited Duty Availability). (ELM 545.62)

SEE Section 6.8, Processing Medical Payments, for payment of medical bills beyond the second visit.

6.2 Reviewing Medical Documentation — *ICCO*

Obligation: Monitoring Medical Progress

The USPS monitors the employee's medical progress and duty status by obtaining periodic medical reports to determine if the employee will be able to return to work in the near future or to further clarify medical work restrictions imposed.

☐ Review the medical evidence and address the following:

— Whether the medical findings indicate the employee is capable of returning to either full or limited duty.
  – If capable for full duty, immediately return the employee to his or her regular position.
  – If capable for limited duty, arrange for a limited duty assignment. If the employee is already on limited duty, determine if the medical findings indicate if the restrictions have been either increased or decreased and if so, change the employee's limited duty assignment accordingly.

— Whether the cited period of disability is consistent with the nature of the injury. Consult with either the OHNA or the USPS contract medical provider.

— Whether information provided in Block 12 of CA-17 is consistent with Side B of Block 7.

— Note that, because of unfamiliarity with the forms, physicians sometimes indicate in Block 12 that the employee is incapable of returning to work; however, a review of the restrictions may reveal that the employee can perform limited duty tasks.

— Whether the medical findings indicate that therapy is required. If so, do the following:
  – Advise the installation head to emphasize to the employee the importance of participating in scheduled therapy treatment to facilitate the recovery process.
  – Report, in writing, missed appointments to OWCP.

— Whether a referral request for nurse intervention is appropriate (see Exhibit 6.2a, Medical Management Tools, and Exhibit 6.2b, Sample Letter: Referral Consideration for the Nurse Intervention Program).

SEE Chapter 7, Limited Duty Program Management.

6.3 Contacting the Treating Physician — *ICCO*

☐ When the USPS medical provider or OHNA is unable to do so, contact the treating physician if additional information is needed because of inconsistencies relative to the employee's duty status or if there are incomplete medical reports. (ELM 545.62) The designated control point may contact the treating physician if clarification is needed following the initial examination.

☐ When making such contacts, ensure the following:

— USPS personnel and the staff of USPS contract medical providers are not interfering with the medical care prescribed by the employee's attending physician.

— Inquiries are limited to information regarding the medical condition of the employee, or the employee's ability to return to full or limited duty.

☐ When communicating with the treating physician, professionally present the pertinent facts and request the treating physician's medical opinion.

☐ Contact the treating physician when requesting a new CA-17, updating medical progress. Ensure that the following are accomplished:

— Document any change in duty status authorized by the treating physician.

— When duty status information is given, issue a new CA-17 with a cover letter, requesting the treating physician to confirm the information in writing.

— Send copies of such correspondence to the employee and to the OWCP district office, and forward copies of the physician's response to both, once it is received.

◇ *Assignment of employee to appropriate duty status must not be delayed. If written confirmation from the treating physician is pending, initiate the assignment based on information received in the documented telephone contact.*

6.4 Initiating a Fitness-for-Duty Examination — *ICCO, OHNA*

Fitness-for-Duty Examination

A fitness-for-duty examination (FFD) is a physical examination conducted by a contract medical provider to determine the employee's current medical status. The purposes of the FFD are to evaluate medical status, confirm or verify limited duty assignments, and assist in the rehabilitation effort.

☐ Initiate an FFD at any time if there are unresolved questions regarding the employee's duty status (ELM 547.3).

◇ *Unsupported findings of disability or unresolved inconsistencies may be challenged by the ICCO personnel.*

☐ The FFD may include the parts of the anatomy being treated as a result of the job-related injury, provided the examination in no way disturbs or interferes with the treatment regimen.

Remember that the purpose of the FFD is to determine the employee's capability of performing work. Therefore, if the employee is obviously totally incapacitated (e.g., immobile), an FFD would be inappropriate. The fact that an injured or ill employee is scheduled for a series of treatments or appointments with a physician or hospital does not by itself, however, establish that the employee is not fit for duty.

☐ Schedule an appointment for an FFD following approval of appropriate official with the USPS contract medical provider as follows:

— Schedule the FFD as soon as possible after the employee's appointment with his or her treating physician. This will allow the USPS contract medical provider to review the most current medical information at the time of the FFD.

— Issue a scheduling letter to the employee. (It is encouraged that two copies be sent: one by regular mail and one by certified mail with return receipt requested) directing him or her to report for the FFD (see Exhibit 6.4, Sample Letter: Employee FFD Scheduling). Prepare the letter for the signature of the district HR manager, and include the following information:

  – Reason for the FFD in accordance with ELM 547.3.
  – Date, time, and location of the examination.
  – Instructions to bring updated medical information.
  – Possible consequences if employee fails to appear.

— When a short lead time cannot be avoided, contact the employee by phone, and follow up with written confirmation.

☐ When the employee fails, without good cause, to appear for the FFD, contact the local labor relations office to discuss possible administrative action. Advise

OWCP if the employee does not report for the FFD examination and request the claims examiner to schedule the employee for a second opinion examination if the employee continues to be uncooperative.

6.5 Initiating a Fitness-for-Duty Examination Consultation — *ICCO, OHNA*

☐ An FFD consultation occurs when the USPS contract medical provider requires a board-certified specialist's opinion, requires a specific test to be performed before rendering his or her own opinion regarding the employee's condition, or when permanent personnel actions are being considered (e.g., permanent reassignment under the USPS in-house rehabilitation program). In these instances, initiate the following:

- — Coordinate efforts with the USPS contract medical provider or the OHNA.
- — Schedule an appointment with an appropriate board-certified specialist (or laboratory or facility for a test).
- — Send a letter to the board-certified specialist or laboratory including or indicating the following:
  - – A statement of what information is needed, the type of test to be performed, and billing instructions.
  - – A summary of the employee's pertinent medical history. (Include appropriate medical reports, test results, etc.)
  - – The signature of either the USPS contract medical provider or the OHNA. If neither are available, the senior IC specialist can sign the letter (see Exhibit 6.5a, Sample Letter: Board-Certified Specialist FFD Consultation Scheduling).
- — Send a second scheduling letter to the employee that contains the information as listed above that advises him or her that the consultation is part of the previously initiated FFD and instructs the employee to bring updated medical information (see Exhibit 6.5b, Sample Letter: Employee FFD Consultation Scheduling). It is encouraged that two copies of the letter be sent: one by regular mail and one by certified mail with return receipt requested.

☐ If the USPS contract medical provider wants to see the employee again following an FFD consultation, schedule the employee for a follow-up FFD. Follow the procedure mentioned in 6.4, Initiating a Fitness-for-Duty Examination.

6.6 Responding After the Fitness-for-Duty Examination Decision — *ICCO*

☐ Obtain a copy of the USPS contract medical provider's medical opinion. Advise the employee of the FFD results in writing (usually with a copy of Form 2485, *Medical Examination and Assessment*), if the USPS contract medical provider has not already done so.

Remember that the FFD determination is not limited to the employee's regular duties but is based on whether the employing installation can provide alternative duties that the employee can perform safely.

☐ When the USPS contract medical provider agrees with the treating physician, do the following:

— Place the employee (or have him or her remain) in the appropriate duty status (e.g., fit for limited duty).

— If deemed appropriate based on medical findings, schedule the employee for a follow-up FFD (e.g., medical findings may indicate employee is currently totally disabled, but is expected to improve within 2 weeks).

— Obtain copies of all pertinent medical reports for referral to OWCP.

☐ When the USPS medical provider needs to clarify the employee's duty status because of incomplete medical reports, lack of specific or conflicting medical restrictions from the treating physician, ensure that the USPS medical provider does the following:

— Contacts the treating physician to attempt to obtain the clarifications.

— Follows up with written confirmation when a change in duty status occurs when advised by the ICCO.

◇ *Physicians under contract to the USPS who are not considered postal employees are not allowed by federal regulations to contact the employee's medical provider.*

Authority for Medical Issues

No administrative action may be taken to change the employee's compensation or duty status until all medical issues are resolved. When the USPS contract medical provider does not agree with the treating physician, the injured employee's duty status may not be changed without the concurrence of the treating physician.

OWCP has sole authority regarding the disposition of medical issues, and the medical data on which the OWCP decision is based become the ruling medical authority. OWCP will determine if a second opinion or an independent medical examination (IME) is required and will schedule the appropriate examinations. Therefore, work assignments are determined in accordance with the medical suitability and work restrictions identified, not with what the treating physician submitted.

For purposes of work assignment, the USPS contract medical provider is permitted to further restrict an employee's work activities, but cannot lessen the restrictions placed on the employee by the treating physician or the OWCP's medical authority determination.

☐ When contact with the treating physician fails to resolve the difference in medical opinions, do the following:

— Obtain a detailed report from the USPS contract medical provider that includes medical rationale to support his or her opinion along with all supporting documentation.

— Prepare a controversion or challenge package for submittal to the OWCP district office upon receipt of the USPS medical contract provider's report.

SEE Chapter 8, Controversion and Challenge.

USPS Contract Medical Provider Review of Medical Evidence

A review by the USPS contract medical provider is critical in cases involving any question about the following:

— The employee's fitness for full or limited duty.

— A relationship between the job-related injury and preexisting medical problems.

— A causal relationship between the medical condition and factors of employment.

— The employee's achievement of maximum medical improvement.

— The use of a medical consultant or specialist by OWCP for a second opinion or an IME. The use of a board-certified specialist as part of an FFD does not constitute a "second opinion" under the intent of FECA. The use of a specialist can, however, further support the opinion of the USPS contract medical provider.

— A change of employee's treating physician.

☐ Monitor status by reviewing OWCP correspondence. If necessary, request periodic status updates using Form 2573, *Request — OWCP Claim Status*.

If OWCP fails to respond within a reasonable period of time (e.g., 8–12 weeks), refer the matter to the designated area HR analyst.

☐ Upon receipt of OWCP's decision, take one of the following actions:

— If the ICCO agrees with the decision, place the employee in the following work assignments:

  – If the employee is found fit for limited duty, see Chapter 7, Limited Duty Program Management.

  – If the employee is found fit for the Rehabilitation Program, see Chapter 11, Rehabilitation Program.

- If the employee is found fit for full duty, issue a letter directing the employee to report back to his or her regular position.

— If the ICCO disagrees with the decision and has evidence to support such disagreement:

- Contact the designated area HR analyst by telephone and review the case.
- If the area HR analyst is in agreement with the ICCO's position, forward the case to the area HR analyst for further follow-up with the OWCP district office and, if necessary, USPS Headquarters.
- Use HRIS call-ups to monitor medical progress through resolution.

SEE Chapter 7, Limited Duty Program Management
Chapter 11, Rehabilitation Program

6.7 Contacting the Occupational Health Nurse Administrator for Assistance in Claims Management — *ICCO*

☐ IC personnel may contact the OHNA for the following information:

- — A list of injured or ill employees on COP, OWCP rolls or limited duty, or in the Rehabilitation Program maintained to assist the ICCO office in tracking IC claims.
- — Review of interim medical reports from the treating physician to monitor the treatment and prognosis for recovery.
- — Assistance in facilitating return of the employee to regular duty and ensuring job suitability for those who cannot return to regular duty.

Medical Payments

When medical expenses are incurred...

6.8 Processing Medical Bills — *ICCO*

Medical Payments

Medical payments may be paid either by the USPS or OWCP. The USPS pays medical bills for the following:

— First-aid cases treated by USPS contract medical providers.

— Management directed medical services, e.g., FFDs, consultative examinations, and tests.

Medical bills arising from these visits, including first-aid visits, may include office visits, X rays, lab work, pharmaceutical bills, and miscellaneous medical expenses. Use HRIS to generate the Medical Bill Certification Form to authorize payment of medical bills for job-related injuries that are not paid by OWCP.

OWCP pays for all medical bills resulting from a job-related injury or illness for which a CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation* or CA-2, *Notice of Occupational Disease and Claim for Compensation*, is filed, except medical management services (see Exhibit 6.2a, Medical Management Tools).

☐ When payment is made by the USPS for first-aid bills or management-directed medical services, make arrangements for local payment by using AIC 577, Medical Expenses — On-the-Job Injury or Illness, and support with a completed medical bill certification (MBC) form.

☐ Provide documentation by doing the following:

— Date stamp all bills.

— Enter the data into the HRIS Medical Management Application, and use the system to generate a completed MBC form.

☐ When first-aid treatment is provided by a USPS contract medical provider, and the employee elects not to file CA-1, *Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation*, initiate the processing of the bill, using Form 7381, *Requisition for Supplies, Services, or Equipment*, and charge the bill to AIC 578.

☐ Provide documentation by doing the following:

— Date stamp all bills.

— Enter the data into the HRIS Medical Management System, and use the system to generate a completed MBC Form.

— Ensure that the completed MBC form is signed by the senior IC specialist.

— Forward the completed MBC form, with the bill, to Finance for payment.

☐ When treatment continues beyond the initial first two visits for first-aid treatment provided by a USPS contract medical provider and payment is made by OWCP, do the following:

— Advise OWCP in writing to preclude dual payment for the initial two visits.

— Instruct the USPS contract medical provider to establish a new account when submitting subsequent bills (after two visits) to the OWCP.

— Date stamp all bills. Bills, other than hospital and pharmaceutical bills, are submitted on HCFA-1500, *Health Insurance Claim Form*.

— Forward the bills to OWCP as soon as possible but no later than l0 working days after receipt.

6.9 Reviewing Medical Payments — *ICCO*

☐ When medical bills are paid by the USPS, obtain the HRIS-generated logs and summaries of local payments to track and monitor the medical expenses.

☐ When medical bills are paid by OWCP, do the following:

— Review bill payments monthly to determine if any duplicate or erroneous payments were made and to facilitate timely corrective action, when needed, by accessing the Exceptions segment of the Bill Payment System (BPS) under the WCIS.

— Upon identification and verification of a duplicate or erroneous payment, submit all pertinent information to OWCP with a request to collect the overpayment and credit the USPS on the chargeback report. Forward a copy of the bill and payment in question to the area HR analyst.

◇ *Contact the area HR analyst when assistance is needed for either the identification or collection of duplicate or otherwise erroneous bill payments.*

Exhibit 6.1
Sample Letter: Limited Duty Availability

[U.S. Postal Service Letterhead]

___[date]___
___[name]___ (treating physician)
___[street address]___
___[city, state, ZIP Code]___

File Number: _[OWCP case number]_

Date of Injury: _____

Dear ___[name]___:

We understand that you are providing medical care to our employee, ___[name]___, secondary to the job-related injury he or she sustained on ___[date]___.

When a postal employee is injured in the performance of duty, our aim is to ensure that he or she receives prompt medical attention and other benefits as provided by the Federal Employees' Compensation Act (FECA). Under this Act, we have an obligation to provide suitable limited duty work, and employees have an obligation to return to work or seek work when able.

Accordingly, if ___[Mr./Ms. name]___ is physically unable to perform the activity outlined on the enclosed CA-17, *Duty Status Report*, side A (Supervisor portion), alternative work is generally available. **[Inclusion of the following sentence is optional.]** Attached are a few examples of the types of limited duty assignments that are available.

Kindly complete side B (Physician portion) of the CA-17. If you indicate that ___[Mr./Ms. name]___ has physical restrictions, we will make every effort to provide an accommodation fully consistent with the restrictions imposed. Please return the CA-17 in the self-addressed envelope provided.

Should you have any questions, please call our contract medical provider or occupational health nurse administrator at ___[telephone number]___. Thank you for your attention to and cooperation in this matter.

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

Enclosure: CA-17, *Duty Status Report*

Exhibit 6.2a

Medical Management Tools

Office of Workers' Compensation Program's Early Nurse Intervention Program

The Office of Workers' Compensation Program's (OWCP) Early Nurse Intervention Program uses registered nurses to intervene in identified compensation cases for purposes of assisting the injured employee, shortening the period of disability, and reducing compensation costs. The nurses interact with the injured employee, treating physician, employing office, and claims examiner to hasten the worker's recovery from the effects of the injury, and to promote a return to the pre-injury level of activities.

The role of the nurse is as follows:

— Establish a supportive relationship with the injured worker and instill confidence that the medical management effort can be effective, beneficial, and lead to resumption of activities of the pre-injury level.

— Provide the injured worker an opportunity to discuss the injury and the medical treatment.

— Gather sufficient information about the injured worker's condition and ongoing medical treatment to recommend and coordinate appropriate medical services designed to expedite recovery.

— Assist the treating physician and injured worker to establish the best timing for and choice of medical services and treatment modalities.

— Monitor the injured worker's medical condition and the treatment provided.

— If necessary, assist the injured worker in obtaining authorizations or other services from OWCP district offices as well as provide information to OWCP about non-work-related medical conditions that may affect recovery.

— Encourage the injured worker to cooperate with medical treatment and other efforts to prepare for return to a higher level of activity and, as feasible, return to work.

— Assist in identifying and reviewing the limited duty assignment.

Currently, OWCP attempts to have nurse intervention occur within 45–90 days after the date of injury. The OWCP claims examiner decides which cases will be referred to the program. The program is especially useful in cases of orthopedic disability. Cases involving surgery, prolonged treatments such as physical therapy without clear goals or direction, multiple concurrent medical and psychological issues, and catastrophic injuries are also likely to benefit from the program.

Although the claims examiner decides whether a case should be referred for inclusion in this program, the ICCO may request the claims examiner to consider specific cases for referral. While the program is designed to target new injuries, other cases may also be recommended (e.g., medically stagnant cases). After a referral request is initiated, use Human Resources Information System (HRIS) to check on status (see Exhibit 6.2b, Sample Letter: Referral Consideration for the Nurse Intervention Program).

Medical Initiatives

In addition to the OWCP Early Nurse Intervention Program described above, there are other management tools available to assist ICCO personnel in returning injured employees to work or bringing cases to a resolution. USPS medical contract provider services should be coordinated with the area medical director for his or her advice and professional opinion.

Medical Management Services

There are numerous private concerns that provide a variety of medical management services, including in-depth assessments of all medical documentation and other pertinent data. Such services have proven beneficial in certain cases involving review of complex medical issues.

Some companies allow for contracting on a case-by-case basis. When considering whether to contract with a medical management service, contact three to five of the company's clients to determine their degree of satisfaction with the services, fees charged, and return on investment.

Routine Use of Records

Authority for disclosure of medical information for routine use of records to nonpostal personnel is cited in ASM 120.098 (f) under Routine Uses of Records Maintained in the System. The routine use of records cited in section (f) provides disclosure to agents and contractors where records or information may be disclosed to an expert, consultant, or other individual who is under contract to the Postal Service to fulfill agency function, but only to the extent necessary to fulfill that function.

Physical Capability Testing

Many rehabilitation and therapy services offer a variety of testing techniques as a tool to help determine an injured worker's capability to return to work. It must be noted, however, that the testing itself is of little benefit unless used as a diagnostic tool to assist an authorized physician (preferably a board-certified specialist) in developing a medical opinion. If deemed appropriate by the USPS contract medical provider, testing would be conducted as part of the FFD. It is imperative that the physician who will be using the results of these tests be familiar with and have confidence in the testing techniques being utilized. This must be established before entering into a contract with a testing service.

Another available testing procedure includes the following:

— *Functional capacity evaluation (FCE).* An FCE is a whole body test that consists of a series of evaluative procedures to determine a worker's physical demand level. It is designed to measure the employee's pain or fatigue level and can be stopped at any time by the patient.

Exhibit 6.2b

Sample Letter: Referral Consideration for the Nurse Intervention Program

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Claimant: _____

File No: ___[OWCP case number]_____

Dear ___[name of claims examiner]___:

It is requested that the above-named claimant be considered for participation in the Nurse Intervention Program. It is believed that this program would be beneficial to ___[Mr./Ms. name]___ for the following reasons:

Thank you for your attention to this matter. If you require additional information or would like to discuss this request, please call the undersigned at ___[telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___

Exhibit 6.4
Sample Letter: Employee Fitness-for-Duty Examination Scheduling

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

File Number: _[OWCP case number]____

Dear ___[name]___:

This is in reference to the job-related injury that you sustained on ___[date]___. As a result of this injury, it is necessary to determine your ability to perform the essential duties of your regular position in either a full or modified capacity (ELM 547.32). You are, therefore, scheduled for a fitness-for-duty examination (FFD). You are directed to report to:

Name of Doctor: _____

Address: _____

_____

Phone: _____

Date: _____

Time: _____

In order to assist the above physician in the medical evaluation, please bring a current narrative report prepared by your treating physician. The report should include the following:

1. Diagnosis.
2. Dates of treatment.
3. Prognosis.
4. Results of pertinent medical studies.
5. Specific work restrictions (if any) and their duration.
6. Prescribed medication, including that which is required while working.
7. Date of anticipated return to work (either full or limited duty).
8. Medical justification for current disability (either total or partial).

During the course of this examination, it may be medically determined that additional testing may be warranted. Therefore, please allow additional time for these studies. It would be helpful if you bring current medical documentation. Failure to report for this examination may be cause for disciplinary action.

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

cc: OWCP Claims Examiner
Postmaster or Manager
Employee's Worksite Contract Medical Provider
File

Exhibit 6.5a

Sample Letter: Board-Certified Specialist Fitness-for-Duty Examination Consultation Scheduling

[U.S. Postal Service Letterhead]

___[date]___
___[name of specialist]___
___[street address]___
___[city, state, ZIP Code]___

Employee:_____

Date of Injury:_____

Dear ___[name of specialist]___:

This is in reference to our employee, ___[name]___, who is scheduled to be examined by you on ___[date]___ at ___[time]___.

To assist you in the examination, following is a brief history of ___[Mr./Ms. name]__'s job-related injury:

[NOTE: The history should include, at a minimum:

- Date of injury.
- Description of accident or exposure.
- Original diagnosis.
- Subsequent diagnoses (if any).
- Length of disability (both total and partial).
- Other pertinent information. (Example: If a concurrent (non-job-related) condition is involved, brief information regarding this condition should also be provided.)]

Please provide your medical opinion regarding the following issues:

[NOTE: The questions requiring a medical opinion should be specific and will vary from case to case. However, as a general rule, these questions should include, but not be limited to, the following:

- Has the employee fully recovered from the job-related injury?
- Is the employee capable of performing his or her regular assignment as reflected on the attached Standard Job Description?
- If employee cannot perform his or her regular assignment, what are his or her physical restrictions? Please indicate by completing the attached Work Restriction Evaluation form.
- Are the current limitations caused or related to the job injury?
- Are the current limitations considered permanent? If not, when can full recovery be expected?]

In addition to the above information, attached are copies of the latest medical reports on file. If you require any additional information, please contact the undersigned on _[telephone number]_.

Please send your report along with your bill to:

_____

_____

_____

Thank you for your assistance in this matter.

Sincerely,

___[signature]___
___[name]___
[Contract Medical Provider/Occupational Health Nurse Administrator/Senior Injury Compensation Specialist]

Attachments: Latest Medical Reports
Standard Job Description*
OWCP-5, *Work Capacity Evaluation*

[*Ensure that the physical requirements of regular job are clearly cited.]

Exhibit 6.5b

Sample Letter: Employee Fitness-for-Duty Examination Consultation Scheduling

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

File Number: __[OWCP case number]__

Dear ___[name]___:

This is in further reference to the job-related injury that you sustained on ___[date]___ and the fitness-for-duty examination (FFD) which was initiated on ___[date]___. As a result of this initial examination, Dr. ___[name of contract medical provider]___ has determined that a consultative examination is necessary before an opinion regarding your duty status can be rendered. You are, therefore, directed to report to:

Name of Doctor: _____

Address: _____

_____

Phone: _____

_____

Time: _____

You may bring updated medical documentation to this examination. If you did not provide a current medical report from your treating physician at time of the above-cited initial FFD, please bring a current report to this examination. The report is to include:

1. Diagnosis.
2. Dates of treatment.
3. Prognosis.
4. Results of pertinent medical studies.
5. Specific work restrictions (if any) and their duration.
6. Prescribed medication, including that which is required while working.
7. Date of anticipated return to work (either full or limited duty).
8. Medical justification for current disability (either total or partial).

Failure to report for this examination without an acceptable reason is just cause for disciplinary action.

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

7. Limited Duty Program Management

Overview

Procedures

Limited Duty Program

When a limited duty program is needed...

Obligation: Assigning Employees to Limited Duty Positions

7.1 Establishing an Informal Limited Duty Program . . . . . *ICCO*

7.2 Establishing a Formal Limited Duty Program . . . . . *ICCO*

Formal and Informal Limited Duty Programs

7.3 Establishing an Effective Tracking System . . . . . *ICCO*

Limited Duty Assignments

When an employee is able to return to work in a limited capacity...

Obligation: Requirement for Written Job Offers

7.4 Offering a Limited Duty Assignment . . . . . *ICCO*

7.5 Following Up After the Limited Duty Assignment is Offered . . . . . *ICCO*

Exhibits

7.1 Limited Duty Assignment Guidelines

7.4 Sample Letter: Limited Duty Assignments

7.5a Sample Letter: Limited Duty Job Offer

7.5b Modified Distribution Clerk Job Description

7. Limited Duty Program Management

Overview

This chapter addresses limited duty provided to an employee who has physical limitations identified by a qualified treating physician stemming from an on-the-job injury or illness. The limited duty program is designed to accommodate injured employees who are temporarily unable to perform their regular functions.

Effective utilization and management of limited duty assignments benefits the USPS as well as the injured employee. These assignments permit employees to work within their medically prescribed physical restrictions. Limited duty often accelerates recuperation as employees generally recuperate faster if they are as active as possible. Moreover, limited duty employees retain the discipline of going to work every day, continue their contribution to the USPS, and are regarded as productive workers. Finally, since limited duty employees work at the job site, they are often motivated to return to their regular job as soon as possible rather than continue doing a lesser skilled limited duty assignment. Early return to the regular job is the ultimate objective of the limited duty program.

Limited duty is an integral aspect of injury compensation program administration and, if managed effectively, makes a significant contribution to cost containment and control initiatives.

Procedures

Limited Duty Program

When a limited duty program is needed...

Obligation: Assigning Employees to Limited Duty Positions

The USPS has legal responsibilities to employees with job-related disabilities under OPM regulations. Specifically, with respect to employees who partially recover from a compensable injury, the USPS must make every effort to assign the employee to limited duty consistent with the employee's medically defined work limitation tolerance. The USPS, in assigning employees to limited duty, must minimize any adverse or disruptive impact on the employee (ELM 546.141).

7.1 Establishing an Informal Limited Duty Program — *ICCO*

☐ Establish a standard procedure that accomplishes the following:

— Requires all injured employees who are partially disabled to report to their regular supervisor.

— Directs supervisors to find appropriate duty for the employee well within the work limitations imposed by the attending physician, and notify the ICCO accordingly.

— Requires IC personnel to assist the supervisor in finding a suitable assignment, if the supervisor's initial response is that he or she does not have any work that the injured employee can do, by doing the following:

  – Review the work restrictions with the supervisor to determine the frequency and duration of physical tasks so as to define the physical requirements and determine exactly what the injured employee can do.

  – If the supervisor is unable to usefully employ an injured employee within his or her assigned work station, broaden the search by following the USPS priority assignment policy and obtain assignment approval from the next appropriate level of management (see Exhibit 7.1, Limited Duty Assignment Guidelines).

7.2 Establishing a Formal Limited Duty Program — *ICCO*

Formal and Informal Limited Duty Programs

A formal program differs from an informal one in that it uses a special job bank set up by the ICCO and appropriate managers. This special bank consists of limited duty tasks that are filled only by injured employees. Normally, this approach is most effective in large installations.

☐ Establish a special bank of limited duty tasks to be filled only by injured employees by doing the following:

- — Analyze the types and numbers of injured employees to determine the most common work restrictions.
- — Identify existing tasks that meet the most common work restrictions.
- — Create limited duty assignments according to the guidelines (see Exhibit 7.1, Limited Duty Assignment Guidelines).

☐ Ensure that each limited duty assignment chosen for the job bank:

- — Has clearly specified physical requirements to enable IC personnel to determine whether the proposed limited duty assignments are safely within the imposed work restrictions established by the treating physician.
- — Has a range of difficulty so that as the injured employee's medical condition improves, the physical demands of the assignment may be gradually increased. Increased physical demand helps promote recovery.
- — Is responsive to USPS guidelines (see Exhibit 7.1, Limited Duty Assignment Guidelines).

7.3 Establishing an Effective Tracking System — *ICCO*

☐ Input into HRIS (or prepare a list of, if necessary) all employees on limited duty, and carry out the following:

- — Generate a status report every accounting period on limited duty employees and provide copies to all functional managers.
- — Require each employee to provide periodic updated medical reports of duty status.
- — Establish call-up dates to monitor the duration of the limited duty status and to coincide with the next scheduled medical evaluation.
- — Review medical documentation with the OHNA or USPS contract medical provider.
- — When the period of limited duty appears to be excessive for the nature or type of injury, or medical documentation lacks supporting rationale, arrange for an FFD. Before the FFD, coordinate with the OHNA or the contract medical provider to discuss the prognosis with the treating physician. Check for additional medical information in OWCP file.
- — If the physician conducting the FFD finds the employee capable of returning to regular duty, request the area medical director or associate area medical director to contact the employee's treating physician and discuss the FFD findings. Forward the FFD findings to OWCP district office with a cover letter.

SEE Chapter 6, Medical Management.

Limited Duty Assignments

When an employee is able to return to work in a limited capacity...

Obligation: Requirement for Written Job Offers

FECA requires that the USPS notify the employee immediately of the description of the job and its physical requirements and of the date the job will be available. To facilitate early return to work, the USPS may contact the employee by telephone, but must provide written confirmation of the job's availability as soon as possible thereafter. (20 CFR (b) (1) and (d) (1) (2)) (ELM 546.62)

7.4 Offering a Limited Duty Assignment — *ICCO*

☐ If medical documentation indicates the employee is capable of performing limited duty, do the following:

- — Identify a limited duty assignment (see Exhibit 7.1, Limited Duty Assignment Guidelines).
- — Ensure that the limited duty assignment is consistent with medically prescribed physical restrictions. Consult with the OHNA, contract physician, or the treating physician if you have any doubts (see Exhibit 6.1, Sample Letter: Limited Duty Availability).

☐ Offer a limited duty job assignment in writing and include the following information:

- — A description of the duties to be performed.
- — The specific physical requirements of the position and any special demands of the workload or unusual working conditions.
- — The organizational and geographical location of the job.
- — The date on which the job will first be available.

If the employee is at the work site and has not lost work time beyond the date of the injury, extend the offer immediately. If the employee is not currently working, initially offer the job by telephone and follow up with a written job offer (see Exhibit 7.4, Sample Letter: Limited Duty Assignments).

7.5 Following Up After the Limited Duty Assignment Is Offered — *ICCO*

☐ If the job offer is accepted:

- — Submit the job offer along with the employee's written acceptance to OWCP.
- — Follow up with the employee to confirm that he or she has returned to duty.
- — Submit CA-3, *Report of Termination of Disability and/or Payment*, to OWCP if there have been periods of disability.

☐ If the job offer is declined:

- — Submit the job offer and declination with a cover letter to OWCP for adjudication.
- — Monitor the case to ensure that OWCP renders a decision as to the suitability of the limited duty job offer and takes appropriate action to terminate or reduce the compensation or COP if applicable (see Exhibit 7.5a, Sample Letter: Limited Duty Job Offer, and Exhibit 7.5b, Modified Distribution Clerk Job Description).

☐ Manage the limited duty assignment to ensure that the employee returns to his or her regular duty assignment at the earliest possible date.

Exhibit 7.1
Limited Duty Assignment Guidelines

Basic Considerations

The USPS should minimize any adverse or disruptive impact on the employee in assigning limited duty. (ELM 546.141)

Consider the following when making limited duty assignments:

— Match the limited duty job as closely as possible to the regular job. Do not make the limited duty job more desirable than the employee's regular job.

— The limited duty work environment should be similar to that of the regular job. If the limited duty environment is more attractive, it may seem like a reward. If the environment is less attractive, it may seem like a punishment.

— The limited duty job should have similar pay. To put an injured employee in a job that pays more than the regular job creates a problem, especially if the employee performs well. To put an injured employee in a lower paying job (i.e., a job that requires less skill) makes poor use of resources.

— Little or no training should be required. Don't expect supervisors to train someone in a skilled assignment when they know he or she will only be there a short time.

— The assignment should result in a tangible product and should not be a "make work" job.

— The assignment should be a function where temporary additional help is useful. This will help ensure that injured employees make a useful contribution to the organization.

Priority for Assignment

Whenever possible, assign qualified employees to limited duty in *their regular craft, during regular tour of duty, and in their regular work facility.*

Prioritize the limited duty assignment in the following manner:

— To the extent that there is adequate work available within the employee's work limitation tolerances, within the employee's craft, in the work facility to which the employee is regularly assigned, and during the hours when the employee regularly works, that work constitutes the limited duty to which the employee is assigned.

— If adequate duties are not available within the employee's work limitation tolerances in the craft and work facility to which the employee is regularly assigned within the employee's regular hours of duty, other work may be assigned within that facility.

— If adequate work is not available at the facility within the employee's regular hours of duty, work outside the employee's regular schedule may be assigned as limited duty. However, all reasonable efforts must be made to assign the employee to limited duty within the employee's craft and to keep

the hours of limited duty as close as possible to the employee's regular schedule.

— An employee may be assigned limited duty outside of the work facility to which the employee is normally assigned only if there is not adequate work available within the employee's work limitation tolerances at the employee's facility. In such instances, every effort must be made to assign the employee to work within the employee's craft within the employee's regular schedule and as near as possible to the regular work facility to which the employee is normally assigned.

If it is necessary to change any of the elements to meet the employee's physical limitations or to provide the employee with suitable work, the elements must be changed in this specific order:

Priority of Choice	Regular Craft	Regular Tour	Regular Facility
1st	Within	Within	Within
2nd	Outside	Within	Within
3rd	Within	Outside	Within
4th	Outside	Outside	Within
5th	Within	Within	Outside
6th	Outside	Within	Outside
7th	Within	Outside	Outside
8th	Outside	Outside	Outside

Questions and Answers About Limited Duty

Q. *What are the differences between limited duty and light duty?*

A. Limited duty is provided to employees who have partial disabilities which stem from a *job-related* injury or illness.

Limited duty does not have to be requested, rather it is made available and offered.

Limited duty comes under the purview of FECA 5 U.S.C. 8101, et. seq.

Normally, light duty is provided to employees who have partial disabilities from *non-job-related* medical conditions.

Light duty must be requested in writing.

Light duty comes under the purview of Article XIII of the National Agreement (including but not limited to American Postal Workers Union (APWU) and National Association of Letter Carriers (NALC).)

Q. *If a full-time employee's schedule is changed as a result of being placed in a limited duty assignment, is such employee entitled to out-of-schedule premium pay?*

A. No. Exceptions to the obligation to pay "out-of-schedule premium" to full-time employees for work performed outside of schedule include situations in which the employee's schedule is temporarily changed for a limited duty assignment as required by FECA, as amended (Handbook F-21, *Time and Attendance*, 232.23b).

Q. *If an eligible employee who is regularly assigned to a night tour of duty is rescheduled to limited duty on the day tour, is the employee entitled to receive an equivalent amount of night differential when rescheduled to day work?*

A. Yes. COP and compensation payments both include night differential. Thus, if the employee is not compensated for the loss in salary (i.e., night differential), the employee would be entitled to COP (if otherwise eligible) or compensation. If the employee is entitled to COP, night differential can be paid as COP and count as a "COP day," even though the employee works 8 hours of limited duty.

Q. *If a limited duty employee is found to have permanent partial disabilities resulting from a job injury, can the limited duty assignment be made permanent?*

A. No. All limited duty assignments are temporary. If medical documentation confirms that an employee has permanent physical restrictions, the employee must be officially reassigned, i.e., a Form 50, *Notification of Personnel Action*, is initiated to show a rehabilitation program classification (see Chapter 11, Rehabilitation Program).

Q. *To what labor distribution code (LDC) or operation should limited duty hours be charged?*

A. Generally, limited duty hours are charged to LDC 68, operation 959.

Q. *Is it mandatory to charge limited duty hours to LDC 68, operation 959?*

A. No. LDC 68 is used to record the hours of all employees who are temporarily assigned to a modified position, either part-time or full-time, in order to accommodate medical restrictions imposed as a result of a job-related injury or illness. This does not include employees who are essentially performing their regularly assigned duties with minor modifications (Handbook F-2, *Functional Management*).

Q. *Can employees on limited duty work overtime?*

A. Yes. An employee can work overtime so long as overtime work is not medically contraindicated. However, under such circumstances, overtime work should be approached with caution.

Q. *How many hours of limited duty should be granted a part-time flexible employee who normally does not work a 40-hour workweek?*

A. Whenever possible, a part-time flexible employee should be granted the number of limited duty hours that are equivalent to the average of the employee's weekly workhours for the 1-year period immediately preceding the date of injury, excluding overtime. (20 CFR 10.205b)

Q. *How many hours of limited duty should be granted a part-time flexible employee who has been employed less than a year?*

A. Whenever possible, an employee should be granted the number of limited duty hours that are equivalent to the average of the employee's weekly workhours during the period of appointment, excluding overtime. (20 CFR 10.205c)

Exhibit 7.4
Sample Letter: Limited Duty Assignments

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

File Number:__[OWCP case number]_____

Date of Injury:_____

Dear ___[name]___:

This letter is in regard to your job-related injury of ___[date]___.

Based on the Office of Workers' Compensation Programs CA-17, *Duty Status Report*, or other medical documentation from your treating physician, it appears that you can perform limited duty work with specified limitations. A copy of this CA-17 or other medical documentation is enclosed.

Federal regulations require injured employees to seek and perform limited duty work when medically able to do so. This letter provides you with a written description of an alternate position or restricted or limited duties to which you may be assigned. The specific duties of this position are described ___[below/in an attachment to this letter]___. You are expected to report to ___[name of supervisor]___ to begin this limited duty work no later than ___[date]___.

In assigning these limited duties we have followed the provisions of the *Employment and Labor Relations Manual* (546.141a) so as to minimize any adverse or disruptive effect on you. If you believe that you are unable to perform these duties for medical reasons related to your injury, you must provide written medical evidence to this effect from your attending physician no later than the date shown in the paragraph above.

Should you have any questions about this notification or the described limited duties, please visit or call the Injury Compensation Control Office ___[name of ICCO]__ at __[telephone number]___.

Sincerely,

___[signature]___
___[name]___
Injury Compensation Supervisor

Enclosures: CA-17, *Duty Status Report*
Modified Job Description

cc: OWCP

Exhibit 7.5a

Sample Letter: Limited Duty Job Offer

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Limited Duty Assignment Offer
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

File Number: _[OWCP case number]_____

Date of Injury: _____

Dear ___[name]___:

This letter is in regard to your job-related injury of ___[date]___.

Based on Office of Workers' Compensation Programs (OWCP) CA-17, *Duty Status Report*, or other medical documentation from your treating physician, it appears that you can perform limited duty work with specified limitations. A copy of this CA-17 or other medical documentation is enclosed.

Federal regulations require injured employees to seek and perform limited duty work when medically able to do so. This letter provides you with a written description of an alternate position or restricted or limited duties to which you may be assigned. The specific duties of this position are described in an attachment to this letter. You are expected to report to begin this limited duty work no later than ___[date]___.

In assigning these limited duties we have followed postal policy and procedures so as to minimize any adverse or disruptive effect on you. If you believe that you are unable to perform these duties for medical reasons related to your injury, you must provide written medical evidence to this effect from your attending physician not later than ___[date]___. If medical evidence is not received by this date, your continuation of pay will be terminated and OWCP will be advised.

Should you have any questions about this notification or the described limited duties, please visit or call the Injury Compensation Control Office ___[name of ICCO]___, at __[telephone number]_.

Sincerely,

___[signature]___
___[name]___
[Senior Injury Compensation Specialist/Control Point Supervisor]

(continued)

I ACCEPT THIS LIMITED DUTY JOB OFFER	I REJECT THIS LIMITED DUTY JOB OFFER FOR THE REASON BELOW
_____	_____
EMPLOYEE'S SIGNATURE	EMPLOYEE'S SIGNATURE
DATE _____	DATE _____

COMMENTS _____

cc: OWCP

Enclosures: CA-17, *Duty Status Report*
Modified Job Description [See Exhibit 7.5b, Modified Distribution Clerk Job Description.]

Exhibit 7.5b

Modified Distribution Clerk Job Description

Employee: John Doe _____ Tour: _____ Days off: _____
Location: _____ Workhours: _____

General Duties:

Manual Distribution of Letter Mail — Separates and files mail according to ZIP Codes into manual distribution case, collects mail for dispatch, and replenishes logs with mail for manual distribution.

Physical Requirements:

Environmental Exposures — indoors only

Standing —	1–3 hours per day (primarily to collect mail and load ledges)
Walking —	1–3 hours per day
Sitting —	6–8 hours per day
Lifting —	5–10 pounds maximum
Carrying —	Handfuls of mail to replenish ledges and place in mail trays for dispatch
Pushing —	None
Pulling —	None
Climbing —	None
Stooping —	None
Kneeling —	None
Crawling —	None
Twisting —	None
Reaching —	Above shoulder level occasionally for 15–45 minutes daily

Mr. Doe does not have to carry regular mail trays, but can replenish ledge by cart or handful, versus normal productive standards. In addition, he is permitted to alternate the sitting and standing at the distribution case as much as he deems necessary for his condition and comfort. He will be primarily filing letter mail into the distribution case.

8. Controversion and Challenge

Overview

Procedures

Basis for Controversion or Challenge

When the USPS decides there is reason to controvert or challenge a claim...

8.1 Establishing a Basis for Controversion or Challenge . . . . . *ICCO*
Obligation: Recognizing the Basis for Controversion or Challenge

8.2 Determining If the Entire Claim, or a Portion Thereof, Should Be Controverted or Challenged . . . . . *ICCO*
Temporary USPS Assignments and COP

Controversion or Challenge

When controverting or challenging a claim...

8.3 Preparing the Controversion and Challenge Package . . . . . *ICCO*
Obligation: Preparing the Controversion and Challenge Package
Importance of the Claim Package
Further References to Use in the Cover Letter

8.4 Submitting the Controversion or Challenge Package to OWCP . . . . . *ICCO*

8.5 Notifying the Employee of Controversion or Challenge . . . . . *ICCO*

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8.6 Responding to OWCP's Formal Decision . . . . . *ICCO*
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8.8 Reviewing the Case and Making the Appropriate Arrangements . *senior IC specialist*

8.9 Disputing the Transcript Findings . . . . . *ICCO*
The Final Decision

8.10 Responding to the Appeal Decision . . . . . *ICCO*

Exhibits

8.3a Sample Letter: Challenge of Entire Claim

8.3b Sample Letter: Challenge of Entire Claim

8.3c Sample Letter: Challenge of Entire Claim

8.3d Sample Letter: Controversion of Entire Continuation of Pay Period — Termination of Pay

8.3e Sample Letter: Controversion of Partial Continuation of Pay Period — Continuation of Pay Not Terminated

8.5 Sample Letter: Employee's Notice of Controverted or Challenged Claim

8.6 Sample Letter: Employee's Notice of Claim Denial

8. Controversion and Challenge

Overview

This chapter addresses situations in which the USPS identifies information in the course of processing a claim that leads it to question the validity of the injury or resulting disability. If, after a thorough review and investigation, this information leads to allegations that are supported by specific factual evidence, and such evidence is relevant to the basic claim requirements, the USPS is obligated to dispute either the entire claim or any element of it by one or both of the following:

— Controversion, i.e., disputing the entitlement of COP for a traumatic injury.

— Challenge, i.e., disputing any aspect of a claim except COP entitlement or disputing the entire claim for either a traumatic injury, occupational disease or illness, or survivor benefits.

The five basic conditions that must be met for a claim to be compensable under FECA are also discussed. The following issues must be considered:

— The claim must be filed within the statutory time limits.

— The injured employee or decedent must be or have been an employee of the USPS at the time of injury or exposure, regardless of the length of time on the job or the type of position held (including casual and transitional).

— The employee or decedent must have sustained an injury as defined in FECA.

— The injury, illness, or death must have resulted from an incident or circumstance occurring while the employee was performing official duties.

— The injury, disability, or death must have been caused by conditions of employment.

The responsibility for satisfying these five conditions rests with the claimant. Once the claimant has made a prima facie case (at first appearance, before investigation), OWCP has the responsibility of making a decision on the basis of evidence presented, or notifying the claimant of what additional information is needed. If the claim has already been accepted and benefits are being paid, OWCP must prove that payments should not continue. (20 CFR 10.110.)

Because the claimant needs only to present a prima facie case, the task of further developing the case rests with OWCP. The mere fact that an employee fails to respond to an OWCP request for further information is not, in itself, cause for denial. Depending on the particular circumstances involved, OWCP claims examiner takes additional measures, including writing directly to physicians and witnesses, scheduling medical examinations, making conference calls, etc. It is essential that the circumstances surrounding a claim be investigated as soon as possible so that the ICCO’s position may be presented in an accurate, professional, and timely manner.

Procedures

Basis for Controversion or Challenge

When the USPS decides there is reason to controvert or challenge a claim...

8.1 Establishing a Basis for Controversion or Challenge — *ICCO*

Obligation: Recognizing the Basis for Controversion or Challenge

It is the responsibility of the ICCO to controvert or challenge a claim if any of the basic requirements or conditions are not met. A case will not be considered compensable by OWCP if it fails to meet any of the five basic requirements or considerations.

☐ When reviewing a claim for possible controversion or challenge, determine if the five basic conditions (see Exhibit 4.6, Conditions for Compensation of Claims) have been met:

- The claim must first satisfy the statutory time requirements of FECA.
- The injured or deceased individual must be an “employee” within the meaning of the law.
- The employee must in fact have sustained an injury or disease.
- The employee must have been in the performance of duty when the injury or illness was sustained.
- There must be a causal relationship between the condition claimed and the injury or disease sustained.

8.2 Determining If the Entire Claim, or a Portion Thereof, Should Be Controverted or Challenged — *ICCO*

☐ Determine if the entire claim, or a portion thereof, should be controverted or challenged:

— Challenge the entire claim, controverting COP if necessary, when there is reason to believe that the employee is not entitled to any of the benefits he or she is claiming. (ELM 545.51 and ELM 545.52)

— *Example*: A claim filed as a traumatic injury is clearly one which is better classified as an occupational disease or illness. In this case, challenge the entire CA-1. Advise the employee to file a CA-2, *Notice of Occupational Disease and Claim for Compensation.*

— Challenge any portion of a claim, controverting COP if necessary (see Exhibit 4.16, Conditions for Continuation of Pay), when there is evidence that the employee is not entitled to specific benefits under FECA.

Example: Medical evidence supports 2 days of disability but the employee takes 4 days. Controvert the last 2 days of COP and withhold COP the last 2 days. (20 CFR 10.204(a)(2)

Example: An employee is on OWCP's periodic rolls. After 2 years of collecting compensation, medical evidence indicates that the disability is no longer related to employment factors. Challenge the continued compensation payments.

SEE Exhibit 4.16, Conditions for Continuation of Pay.

Temporary USPS Assignments and COP

When casual employees or other employees with specific terms of employment are injured, COP is provided only through the end of their appointments (see Chapter 13, Timekeeping and Accounting*).*

Examples:

— If a casual employee is hired for 89 days and is injured on the 84th day, COP is paid only through the 89th day. However, if disability continues beyond the 89th day, CA-7 is initiated 5 working days before the termination of the COP.

— If an employee is hired for an appointment not to exceed 89 days and on the 40th day into the appointment the appointment is changed to 60 days because of lack of work, and then an injury occurs on the 44th day of the appointment, COP is paid through the 60th day.

◇ *In other questionable cases not described above, contact the designated area HR analyst for guidance in determining whether to withhold or terminate COP.*

Controversion or Challenge

When controverting or challenging a claim...

8.3 Preparing the Controversion and Challenge Package — *ICCO*

Obligation: Preparing the Controversion and Challenge Package

The controversion and challenge package must be thoroughly documented and tailored to the facts of each case. If a written explanation of the dispute is not submitted by the USPS, OWCP may accept the employee's report of injury as factual.

Importance of the Claim Package

The importance of a carefully prepared and well-documented claim package cannot be overemphasized.

☐ If the claim form has not already been submitted, review it carefully for completeness and accuracy in preparation for submittal. If CA-1 is used, clearly mark item 35 and provide an explanation for the controversion provided.

Do not delay submitting the claim pending collection of data to support a controversion or challenge.

◇ *Early and proper identification of controverted or challenged claims is essential to permit OWCP to give these claims priority in processing, and to avoid the possibility of substantial or erroneous payment of COP or compensation benefits.*

SEE Chapter 4, Claims Management.

☐ Prepare exhibits that contain the factual information necessary to support the controversion or challenge action. Arrange the exhibits in chronological sequence. Use the following examples as exhibit possibilities:

- — Witness statements, both positive and negative. You may need to include those statements from witnesses, who, although working in the immediate vicinity of the alleged accident, had no knowledge of it.
- — Supervisor's statement.
- — Medical evidence.
- — Diagrams and maps.
- — Photographs.
- — Time and attendance records.
- — Other documents obtained by investigation.

— Investigative memorandum, i.e., results of the investigation conducted by the Inspection Service.

— Results of environmental studies conducted by safety personnel.

☐ Prepare a cover letter, the most important part of the package. Keep the letter brief and construct it to include the following elements:

— An introduction that contains the following information:

  – Claimant identification.

  – Nature of the claim.

  – A statement that the claim, or portion of the claim, is being controverted or challenged.

— Presentation of evidence including the following:

  – Documented evidence, attached as exhibits.

  – Factual information for which supporting documentation may not be available (e.g., knowledge of outside employment). Do not use hearsay information. All evidence must be from credible sources, be complete, and be clear. Use HRIS call-up to track receipt of requested information.

— A simple summary in the last paragraph referring to the FECA statute and containing statements of the following:

  – What is being controverted and why.

  – What is being included as supporting references and attachments.

  – What action is being requested.

SEE Exhibit 8.3a, Sample Letter: Challenge of Entire Claim *Disputed Requirement: Postal Employee*.
Exhibit 8.3b, Sample Letter: Challenge of Entire Claim *Disputed Requirement: Fact of Injury.*
Exhibit 8.3c, Sample Letter: Challenge of Entire Claim *Disputed Requirement: Performance of Duty.*
Exhibit 8.3d, Sample Letter: Controversion of Entire COP Period — COP *Withheld Disputed Requirement: Time.*
Exhibit 8.3e, Sample Letter: Controversion of Partial COP Period — COP Not Terminated *Disputed Requirement: Causal Relationship.*

Further References to Use in the Cover Letter

In addition to acquired evidence, the following may be used to further support the ICCO position:

— Reference to precedent-setting ECAB decisions.

— It is essential, however, to ensure that the ECAB decision is relevant to the case. Caution must be used when comparing a seemingly similar situation. The surrounding circumstances must be considered when determining the applicability of an ECAB decision. ECAB decisions are to be referenced by

name and number, i.e., John Smith, 10 ECAB 921. There is no need to attach a copy.

— Review of content and criteria set forth in applicable *FECA PM.*

— This review can be extremely helpful. Not only does this assist in familiarizing ICCO personnel with FECA terminology, but it provides insight into the rationale used by OWCP when adjudicating the claim.

8.4 Submitting the Controversion or Challenge Package to OWCP — *ICCO*

☐ Submit the package as soon as possible, updating HRIS and filing a copy of the package in the case file.

8.5 Notifying the Employee of Controversion or Challenge — *ICCO*

☐ Notify the employee, in writing, that his or her claim is being controverted or challenged (see Exhibit 8.5, Sample Letter: Employee's Notice of Controverted or Challenged Claim).

Disposition by OWCP

When OWCP renders a decision...

8.6 Responding to OWCP's Formal Decision — *ICCO*

Obligation: Noting OWCP's Pretermination Notice

When evidence of record shows that compensation benefits should be terminated or reduced, the claimant will, in most cases, be issued a written notice of the proposed action and be given the opportunity to submit relevant evidence or argument. A pretermination notice will be provided in virtually all cases where the proposed action is based upon medical or other evidence obtained by OWCP. Such notice is also required in all cases where full periodic payments may be terminated, including cases on the short-term roll, except when termination is based on the following:

— Death of the claimant.

— Return to work.

— Suspension or forfeiture of compensation.

Notice of proposed reduction or termination of compensation benefits does not constitute a formal decision. Therefore, no USPS action may be initiated based on this notice. (See FECA PM 2–1400 for further information.)

OWCP's Formal Decision

OWCP's decision will be issued as either a compensation order or letter of denial with a copy to the USPS.

☐ When the controversion or challenge is upheld, (i.e., compensation benefits are denied), do the following:

— Initiate the following administrative action:

  – Send the Employee's Notice of Claim Denial (see Exhibit 8.6) to the employee initiating claim recovery of benefits.

  – If medically appropriate, direct the employee back to work.

— Ensure that the employee has received his or her appeal rights in the letter from OWCP and monitor any appeal activity.

— Update HRIS and use HRIS call-up to track follow-up actions.

☐ When controversion or challenge is denied by OWCP, i.e., entitlement to compensation benefits is upheld, expect notification by OWCP explaining the rationale for denying the challenge and upholding the claim.

- ☐ If the ICCO disagrees with OWCP's decision and such disagreement is based on valid reasons, discuss the case by telephone with the area HR analyst. If the area HR analyst agrees, forward the case to the area HR analyst's office for resubmission to OWCP.

Appeals

When an employee wishes to appeal OWCP's decision...

Obligation: Recognizing OWCP Final Authority

The final authority in OWCP in the determination of a claim is vested in the director. The decision contains findings of fact and a statement of reasons. A copy of the decision, together with information as to the right to a hearing, to a reconsideration, and to an appeal to the Employees' Compensation Appeals Board, will be mailed to the claimant's last known address. A copy will also be sent to the USPS.

8.7 Ensuring That the Employee Is Informed of His or Her Rights and Obligations — *ICCO*

☐ When reviewing compensation orders or letters of denial, ensure that the employee receives the pertinent appeal rights from OWCP according to the circumstances of the case and advise him or her of the leave options available (see Exhibit 8.6). The USPS has no appeal rights under FECA.

Employee's Appeal Rights and Scheduling a Hearing

Reconsideration. In order to support a request for reconsideration, new evidence or argument for error in fact or law must be submitted within 1 year from date of issuance of OWCP district office decision. This time requirement applies only to decisions rendered on or after June 1, 1987. There is no time limitation for decisions made before this date.

Any request not accompanied by such new evidence will be denied as insufficient prima facie evidence.

Applications for reconsiderations are processed at OWCP district office as outlined in FECA PM 2–1602.

Before reaching a decision, OWCP will provide the USPS with copies of any pertinent new evidence submitted by the claimant and will be allowed 15 days for review and comment. However, new medical evidence will not be provided since it is not considered pertinent for review and comment by the employing agency. OWCP has sole responsibility for evaluating medical evidence.

Hearing. An employee may request a hearing in any case where the injury or death occurred after July 4, 1986. The hearing must be requested before any reconsideration is undertaken. New evidence may be submitted in connection with a hearing, but it is not required. (Section 5 U.S.C. 8124)

In place of an oral hearing, a claimant may request a review of the written record. Such a review would not involve attendance by the claimant. As with the oral hearing, the claimant may submit any evidence or argument deemed relevant.

As with the reconsideration process, the USPS will be provided with copies of pertinent documentation submitted by the employee and allowed 15 days for review and comment.

Applications for hearings and reviews should be mailed within 30 days of issuance of OWCP district office's decision. They are processed by the Branch of Hearings and Review, OWCP National Office, as outlined in FECA PM 2–1601.

Review by ECAB. ECAB will not consider new evidence; therefore, any appeal to this body will proceed on the basis of the record as it stands at the time OWCP decision was made.

Requests for appeal should be filed within 90 days from the date of OWCP district office decision for employees in the U.S. or Canada (180 days for employees residing outside the U.S. or Canada); however, ECAB may extend the period for filing up to 1 year if good cause is shown for the delay.

ECAB is a separate entity from OWCP within DOL. ECAB processes review applications as outlined in *FECA PM* 2–1603.

Scheduling a Hearing

OWCP hearing representative will mail a notice to the employee or the employee's representative, and to the USPS, specifying the date, time, and place for the hearing at least 15 days before the scheduled hearing date. With the exception of unusual circumstances, hearings will be scheduled within 100 miles of the claimant's home. (The USPS will receive a separate notice advising of its right to have a representative attend the hearing and obtain a copy of the hearing transcript.)

The employee may withdraw the request for a hearing at any time before the hearing by written notice, or on the record at the hearing itself. The request for postponement must be in writing, must be received by the Branch of Hearings and Review at least 3 days before the date of the scheduled hearing, and must show good cause for postponement.

If the employee fails to appear at a scheduled hearing, he or she may request that another hearing be scheduled, but must do so within 10 days after the date set for the hearing.

8.8 Reviewing the Case and Making the Appropriate Arrangements — *senior IC specialist*

☐ When notice of a hearing is received, review the case to determine whether attendance at the hearing is necessary.

◇ *The USPS need not send a representative in every case but should send a representative to those hearings that involve fact of injury, performance of duty, or special interest.*

☐ Complete OWCP hearing notice that asks if the USPS will send a representative to the hearing and if the USPS wishes to receive a copy of the hearing transcript.

◇ *Always request a copy of the transcript. You may also need to request a copy, in writing, at the hearing.*

☐ Select a USPS representative to attend the hearing, e.g., the senior IC specialist, the HR specialist handling the case, a USPS attorney, etc. Make the necessary arrangements and inform the representative that he or she is to attend the hearing as an observer without the right to question or participate in any manner unless the claimant or the hearing representative specifically requests information from the USPS.

☐ Ensure that the USPS representative reviews and is thoroughly familiar with, the claimant's OWCP case and related grievances, i.e., EEO complaints and Merit Systems Protection Board actions.

☐ Confirm the day before the scheduled hearing and by telephone that the hearing is still planned.

8.9 Disputing the Transcript Findings — *ICCO*

☐ When the hearing transcript is received, thoroughly review all the facts presented in the transcript, make written notations where conflicts exist, and compile any additional documentation that would substantiate the USPS position.

☐ Prepare a letter to OWCP hearing representative citing the areas in dispute with supporting documentation attached. List the disputed areas in sequence as they appear in the transcript and identify them by page number and paragraph. Submit this letter to OWCP hearing representative within 15 days following the release of the transcript.

If a written explanation of the dispute is not submitted, OWCP may accept the employee's report of injury as factual.

☐ Send a copy of the response to the claiment or the claiment's authorized representative.

◇ *If cases involve complex issues that warrant legal analysis or further interpretation of FECA or USPS policies, refer to the chief field counsel and the designated area HR analyst for assistance and guidance.*

The Final Decision

If the OWCP hearing representative who is evaluating the evidence and testimony, needs additional case development, he or she will remand the case back to the OWCP district office.

When all evidence and testimony are evaluated, OWCP hearing representative will issue a decision that affirms, reverses, remands, or modifies OWCP district office's decision.

8.10 Responding to the Appeal Decision — *ICCO*

- ☐ If the decision is adverse to the claimant, advise the employee of his or her appeal rights again.
- ☐ If a new OWCP decision is received, take the same steps described in 8.6, Responding to OWCP's Formal Decision.

Exhibit 8.3a

Sample Letter: Challenge of Entire Claim

Variant for Disputed Requirement: Postal Employee

[U.S. Postal Service Letterhead]

___[date]___
___[name of claims examiner at Office of Workers' Compensation Programs]
___[street address]___
___[city, state, ZIP Code]___

Name:_____

SSN:_____

File No: __[OWCP case number]_____

Dear ___[name]___:

This is in reference to ___[name]___ who was injured on ___[date]___ when he/she was involved in a motor vehicle accident. ___[name]___ filed a CA-1 on ___[date]___ (Attachment 1). Since ___[name]___ is not an employee of the U.S. Postal Service, his/her entitlement to Federal Employees' Compensation Act (FECA) benefits is being challenged. Please be aware that continuation of pay has been withheld.

[Describe the circumstances, e.g.:

The U.S. Postal Service has a contract with Highway Services Trucking, Inc. to transport mail (Exhibit A — Copy of Contract). Mr. Stayman is employed by Highway Services Trucking, Inc. as a driver. Mr. Stayman is not on the U.S. Postal Service payroll nor does the U.S. Postal Service have any direct supervisory authority over him.]

In view of the above, it is requested that ___[name]___'s claim for benefits be denied since ___[he/she]___ is not a Postal Service employee under the purview of FECA.

Your attention to this matter is appreciated.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: [List all documents in the claim package.]

Exhibit 8.3b

Sample Letter: Challenge of Entire Claim

Variant for Disputed Requirement: Fact of Injury

[U.S. Postal Service Letterhead]

___[date]___
___[name of claims examiner at Office of Workers' Compensation Programs]
___[street address]___
___[city, state, ZIP Code]___

Name: _____

SSN:_____

File No: __[OWCP case number]_____

Dear ___[name]___:

This letter is in reference to our employee, ___[name]___, ___[title]___, who filed a CA-2, *Notice of Occupational Disease and Claim for Compensation,* for stress on ___[date]___. The initial claim package was forwarded to your office on March 8, 1995. Based on an investigation into the circumstances surrounding this claim, we are challenging ___[name]___'s entitlement to Federal Employees' Compensation Act (FECA) benefits.

> [Describe the circumstances, e.g.:
> On January 22, 1995, Ms. Ruby filed an Equal Employment Opportunity (EEO) complaint alleging she was being harassed by her supervisor. She cited the manner in which he spoke and assigned work to her as the source of the harassment. This allegation was investigated via the EEO process and a decision was rendered on February 28, 1995. The decision concluded that the preponderance of evidence failed to support a finding of harassment (Attachment 1 — Statement from senior EEO management representative at local office.)
>
> On March 2, 1995, Ms. Ruby was seen by her treating physician, Dr. Samuel S. Stone. Ms. Ruby provided Dr. Stone with the same history of harassment as mentioned above. However, she failed to mention to Dr. Stone that the allegation of harassment was found to be unsupported upon investigation. Dr. Stone diagnosed Ms. Ruby with stress-related disability because of harassment in the workplace (Attachment 2 — copy of Dr. Stone's report). Ms. Ruby provided an inaccurate history regarding her allegation. She implied to both her treating physician and your office that the harassment was a matter of fact. However, the evidence of record failed to support this finding.]

In view of the above, it is our contention that ___[name]___ has not established fact of injury and ___[his/her]___ entire claim should, therefore, be denied.

(continued)

Your favorable consideration of this request is appreciated.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: [List all documents in the claim package.]

Exhibit 8.3c

Sample Letter: Challenge of Entire Claim

Variant for Disputed Requirement: Performance of Duty

[U.S. Postal Service Letterhead]

___[date]___
___[name of claims examiner at Office of Workers' Compensation Programs]
___[street address]___
___[city, state, ZIP Code]___

Name:_____

SSN:_____

File No: __[OWCP case number]_____

Dear ___[name]___:

This is in reference to our employee, ___[name]___, ___[title]___, who alleges that he/she was injured on ___[date]___. Circumstances surrounding his alleged ___[injury type]___ provide grounds for challenging the entire claim.

> [Describe the circumstances, e.g.:
> On the date of the alleged injury, Mr. Doe was observed reporting for work with a noticeable limp in his right leg (Exhibit A — Statement from Supervisor). Upon returning from his route, Mr. Doe reported that he had tripped over a sprinkler head at 202 Deerfield Lane and injured his right leg. He requested medical treatment and was issued a CA-16 to see Dr. Fawn.
>
> After our safety specialist investigated the premises at 202 Deerfield Lane, he discovered that there was no sprinkler system at that address (Exhibit B — Statement from Safety Specialist). Further investigation revealed that a fellow employee named Mr. Buck had seen Mr. Doe, an avid tennis player, playing tennis at the local park on March 5, 1995, the evening before the alleged injury (Exhibit C — Statement from Mr. Buck).]

Based on our investigation, it appears that ___[name]___ did not sustain ___[his/her]___ injury while in the performance of duty. We request, therefore, that ___[name]___'s entire claim be disallowed.

Your timely adjudication of this claim would be greatly appreciated.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: [List all documents in the claim package.]

Exhibit 8.3d

Sample Letter: Controversion of Entire Continuation of Pay Period — Termination of Pay

Variant for Disputed Requirement: Time

[U.S. Postal Service Letterhead]

___[date]___
___[name of claims examiner at Office of Workers' Compensation Programs]
___[street address]___
___[city, state, ZIP Code]___

Name:_____

SSN:_____

File No: __[OWCP case number]_____

Dear ___[name]___:

This is in reference to our employee, ___[name]___, ___[title]___, who sustained a work-related injury on ___[date]___.

Because of untimeliness, ___[name]___'s entitlement to continuation of pay (COP) is being controverted. Please be aware that pay has been terminated in this case.

[Describe the circumstances, e.g.:

As reflected on the attached CA-1, Mr. Dolphin sustained his injury on August 8, 1995. However, the CA-1 was not filed until October 8, 1995.]

In view of the above, ___[name]___has failed to meet the 30-day statutory reporting requirement. Therefore, it is requested that ___[name]___'s claim for COP be denied.

Thank you for your attention to this matter.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: [List all documents contained in the claim package.]

Exhibit 8.3e

Sample Letter: Controversion of Partial Continuation of Pay Period — Continuation of Pay Not Terminated

Variant for Disputed Requirement: Causal Relationship

[U.S. Postal Service Letterhead]

___[date]___
___[name of claims examiner at Office of Workers' Compensation Programs]
___[street address]___
___[city, state, ZIP Code]___

Name:_____

SSN:_____

File number:___[OWCP case number]_____

Dear ___[name]___:

This letter is in reference to our employee, ___[name], ___[title]___, who was injured on ___[date]___ when ___[describe injury]___. Because of a lack of supporting medical documentation, ___[name)___'s entitlement to ___[number]___ hours of continuation of pay (COP) is being controverted. As information, payment of COP was not terminated.

> [Describe the circumstances, e.g.:
> On April 1, 1995, Ms. Sunflower was seen by her treating physician, Dr. Rose, who diagnosed her as totally disabled for April 1 and April 2, 1995 (Attachment 1– CA-17). However, she did not return to work until April 5th. On April 3, Ms. Sunflower's supervisor, Mr. Tulip, placed a follow-up call to Dr. Rose's office. This call confirmed that Ms. Sunflower was, in fact, released to return to work on April 3 (Exhibit A — Statement from Supervisor). On the same date, Ms. Sunflower was advised by telephone, as well as by written confirmation, that medical evidence was required to support disability subsequent to April 2, 1995 (Exhibit B — Copy of Confirmation Letter to Employee). As of this date, no additional medical evidence has been received.]

In view of the above, ___[name]___ has not established that ___[his/her]___ absence on ___[date]___, was due to ___[his/her]___ work-related injury. It is, therefore, requested that COP be denied for ___[period]___.

Thank you for your review of this matter.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: [List all documents in the claim package.]

Exhibit 8.5

Sample Letter: Employee's Notice of Controverted or Challenged Claim

With Variant for Withholding or Termination of COP

Certified — Return Receipt Requested
[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

Dear ___[name]__:

This is in reference to your injury claim filed on ___[date]___ for ___[nature of injury]___ . Under the Federal Employees' Compensation Act, the U.S. Postal Service may formally express opposition to a claim whenever doubt exists as to entitlement to benefits. In regard to your claim, this office disputes your entitlement to ___[benefit(s) being controverted or challenged]___ for the following reason(s): ___[reason(s) for dispute]___.

All pertinent documents have been sent to the Office of Workers' Compensation Programs (OWCP). However, you can submit the medical reports and/or related bills directly to OWCP. If you choose to send information directly to OWCP, please furnish a copy of the medical report to the Injury Compensation Control Office (ICCO) to ensure that appropriate and timely actions are taken with regard to the claim. For your convenience, you may continue to submit this information to the ICCO for prompt handling and submission to OWCP. Upon adjudication, OWCP will issue a final decision in writing.

> **[If applicable, add a statement regarding the withholding or termination of COP. Also add:]** Please be aware that pay has been terminated pending OWCP's decision. In the interim, you may elect to use either sick or annual leave. If you do not have sufficient leave to cover your absence, you may request regular leave without pay (LWOP). Please advise your immediate supervisor of your election as soon as possible. If election is not made within 7 days from receipt of this letter, your period of disability related to this claim will be automatically charged to LWOP.

If you have any questions or wish to submit additional evidence, you may contact the ICCO at ___[telephone number]___.

Sincerely,

___[signature]___
___[name]__
___[title]____

cc: OWCP District Office
Employee's Supervisor

Exhibit 8.6

Sample Letter: Employee's Notice of Claim Denial

Certified — Return Receipt Requested

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

Dear ___[name]___:

This letter is in reference to the compensation order dated ___[date]___ regarding your Office of Workers' Compensation Programs (OWCP) Claim No. ___[number]___ (copy attached). As indicated by the attached order, your claim for the cited Federal Employees' Compensation Act benefits has been disallowed by the U.S. Department of Labor, OWCP.

It is imperative that you contact your immediate supervisor to arrange for approval of Form 3971 to cover the period of absence involved. Any future absence(s) and/or related medical evidence from this disability should be submitted to your supervisor for approval.

You have the option to substitute sick or annual leave for the continuation of pay you received and/or for the leave without pay/injured on duty (LWOP-IOD) which was entered for you into the payroll system. Please advise your immediate supervisor of your choice of leave. If you do not have sufficient leave to cover your absence during this period of disability, you may request regular LWOP. If you do not make your election within 7 days from receipt of this letter, your absence for the period involved will be changed to LWOP. If you have any questions, please contact the Injury Compensation Control Office at ___[telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___

Attachment: OWCP Compensation Order

cc: Employee's Supervisor

9. Fraud and Abuse

Overview

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Fraud and Abuse

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9.4 Monitoring Fraud and Abuse Cases . . . . . *senior IC specialist*

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9.3a Fraud and Abuse Referral Checklist

9.3b Sample Letter: Referral Memorandum

9. Fraud and Abuse

Overview

This chapter identifies the criteria needed to identify suspected fraud and abuse cases for further investigation by the Inspection Service and outlines procedures for referring cases to the Postal Inspection Service.

The investigation of IC cases involving possible fraud and abuse comes under the jurisdiction of the Inspection Service. The objective of the Inspection Service is to assist ICCO personnel in reducing compensation costs resulting from fraudulent claims and to gather information leading to the removal of dishonest employees from the USPS.

Although the terms *fraud* and *abuse* are related, they are not interchangeable.

Fraud is an intentional deceptive act, or series of acts, committed by an individual with the intent to cause the USPS or OWCP to grant benefits that would not normally be provided under FECA, for example, a faked injury or concealment of facts indicating that an injury occurred off duty.

Abuse is excessive, extravagant, or improper use of FECA in a manner contrary to its legal use in order to acquire additional benefits for personal gain, for example, prolonging the length of the recovery period needed for a job-related injury.

The key difference between fraud and abuse is intent. When employees apply for or receive FECA benefits to which they are not entitled, they are abusing FECA. This abuse may occur because the employees are ignorant of the law and its provisions or because they genuinely feel that they are entitled to those benefits. When employees deliberately apply for FECA benefits that they know they are not entitled to, they are committing fraud. Abuse is not always fraud, but fraud is always abuse.

Since the inception of Inspection Service investigations into FECA fraud and abuse, several distinct types of fraud and abuse have been identified. Some of the types identified are the following:

— Concealing, with intent to defraud, prior injuries or physical impairment when hired.

— Reporting an on-the-job injury when the injury occurred off the job.

— Fabricating an injury or falsifying the extent or seriousness of the real injury.

— Engaging in and concealing outside employment while receiving compensation payments.

— Regularly engaging in activities that are inconsistent with the alleged injury or medical restrictions.

— Failing to return to work after recovering from an injury.

— Continuing to accept compensation when no longer disabled, or no longer an employee of the USPS, or without making any effort to return to work.

Procedures

Fraud and Abuse

When fraud or abuse is suspected...

Obligation: Recognizing the Penalty for Conviction of Fraudulent Workers' Compensation Claim

An individual convicted of a violation of 18 U.S.C. 1920, as amended, or of any other fraud related to the application for or receipt of benefits under Subchapter I or III of Chapter 81 of Title 5, forfeits, as of the date of the conviction, all entitlement to any prospective benefits provided by Subchapter I or III for any injury occurring on or before the date of conviction. Such a forfeiture of benefits is in addition to any action the Secretary may take under section 8106 or 8129 of title 5, United States Code.

If an individual has one or more dependents as defined under section 8110(a), the Secretary of Labor may, during the period of incarceration, pay to such dependents a percentage of the benefits that would have been payable to such individual computed according to the percentages set forth in section 8133(a)(1) through (5).

9.1 Determining If Fraud or Abuse Exists — *supervisor*

☐ To determine whether fraud or abuse may exist, consider the following warning signals:

- — There are no witnesses to the accident (if there were witnesses, consider their reliability), and the circumstances surrounding the injury are suspect.
- — The injury cannot have logically happened as described.
- — The employee sustains a minor accident which resulted in a disabling soft tissue injury with an inconsistent length of disability.
- — The injury is not reported on the day of occurrence.
- — The employee has a history of leave abuse or has previously filed questionable claims.
- — The injury is reported when disciplinary action is pending or leave of any type is denied.
- — The injury occurs shortly before an employee's defined termination date.
- — The employee is known to have recently engaged in outside activities (sports or other work) that could cause similar injury inconsistent with the employee's medical restrictions.
- — The employee has a confrontation with his or her supervisor before the accident.
- — The treating physician handles multiple claims and always indicates disability.

9.2 Responding to a Possible Case of Fraud or Abuse — *supervisor*

Obligation: Submitting Information to OWCP

The USPS has the responsibility to submit to OWCP, at any time, all relevant and probative factual and medical evidence in its possession or evidence that it may acquire through investigation or other means.

☐ When it appears that fraud or abuse has occurred, do the following:

— Immediately notify the ICCO.

— Document all pertinent information.

— Forward all documentation to the ICCO.

9.3 Responding to Notification of Possible Fraud or Abuse — *ICCO*

☐ Using the Fraud and Abuse Referral Checklist (see Exhibit 9.3a) as a guide, determine if the case should be forwarded to the Inspection Service as follows:

— If one or more of the items in Section A are checked, refer the case to the Inspection Service.

— If one or more of the items in Section B are checked, *consider* referring the case to the Inspection Service; however, evaluate each case on an individual basis. Refer a case only when there is strong probable cause to believe fraud or abuse is present.

☐ If appropriate, refer the case to the Inspection Service. Prepare a referral memorandum to be signed by the senior IC specialist and include all pertinent documentation (see Exhibit 9.3b, Sample Letter: Referral Memorandum).

☐ In instances where evidence is likely to be moved or destroyed, or where emergency attention is indicated, immediately contact the Inspection Service by telephone or in person. Follow up the contact, in writing, as indicated above.

☐ Forward the initial claims package to OWCP within the established time frame, regardless of whether the case is referred to the Inspection Service.

☐ Do not include the referral when submitting the claim package because at this stage it has not yet been determined if an investigation by the Inspection Service is warranted.

◇ *Referral methods may vary according to local agreements between the ICCO and Inspection Service units.*

☐ Enter the referral information into a tracking system.

☐ Maintain contact with Inspection Service personnel. They will determine if the case is accepted for investigation (jacketed) or declined.

— If the case is jacketed, the Inspection Service will conduct an investigation.

— If a preliminary review indicates that an additional investigation would be unproductive, the Inspection Service will return the file to the ICCO with an explanation.

☐ Prepare a controversion or challenge package if the Inspection Service's investigation supports the existence of fraud or abuse.

☐ Upon completion of the investigation, the Inspection Service will issue an investigative memorandum to the installation head and a copy to the ICCO containing information that will assist the ICCO in deciding the course of action to be taken.

SEE Chapter 8, Controversion and Challenge.

Inspection Service Reward Program

In accordance with 39 CFR 233, the Inspection Service pays rewards for information leading to the detection of persons or firms who obtain or seek to obtain money, property, or services from the USPS through any fraudulent activity, including the use of false or fraudulent claims or statements, or who successfully reduce or seek to reduce the amount of money owed to the USPS through fraud.

Rewards are payable only from the proceeds recovered through criminal, civil, or administrative action. The amount paid is determined at the discretion of the Chief Postal Inspector, but will not exceed one-half of the amount recovered. Private citizens and postal employees, except postal inspectors and Law Department employees, are eligible to receive rewards. However, these individuals must initiate action for payment of a reward because it is unlawful for any government employee to solicit or suggest the filing of a claim against the government. See Exhibit 9.3a, Fraud and Abuse Referral Checklist, and Form 557, *Application for Reward*, in Appendix D, Forms.

9.4 Monitoring Fraud and Abuse Cases — *senior IC specialist*

☐ At quarterly intervals, review the status of all referrals with the postal inspector assigned to handle local IC matters. Use HRIS call-up dates to schedule review dates and the HRIS-generated pending referrals report to assist in the actual review.

Exhibit 9.3a

Fraud and Abuse Referral Checklist

Employee's Name:_____ DOI: _____

SSN:_____ Nature of Injury: _____

OWCP Claim No.: _____ _____

Questionable Circumstance

Section A

1.	Evidence of falsification or alteration of forms (attach a copy of the form).	
2.	Concealment of prior injuries or physical impairments at the time of hiring (attach a copy of the supporting documentation and statements).	
3.	Incriminating witness statement or admission by claimant (attach a copy of the statement).	
4.	Physical activity inconsistent with the nature of the claimed injury (attach a copy of the information received). Note: It may not be inconsistent for a mail handler with a 70-pound lifting requirement to be seen grocery shopping, for example, or carrying a small child.	
5.	Concealed employment while collecting continuation of pay or Office of Workers' Compensation Programs compensation (attach a copy of the information received).	
6.	Evidence of collusion with a physician (attach name, address, and telephone number of the physician, and the basis for allegation).	

Section B

7.	The employee has a history of leave abuse or questionable prior injuries (attach PS 3972 or a list of prior injuries including date of injury, claim number, and nature of injury).	
8.	The injury was reported in the first pay period of employment. Date the employee began duty:_____	
9.	The injury was reported when disciplinary action was pending or leave of any type had been denied (attach a summary of the circumstances surrounding the case).	
10.	A temporary employee claimed the injury occurred at the end of the employment period.	

(continued)

11. There were no witnesses to the injury, and the circumstances surrounding the injury are suspect. Specify where the injury occurred: _____	
12. The accident was very minor and resulted in a disabling soft tissue injury with an inconsistent length of disability._____	

Other pertinent data:

_____

_____ _____
Signature of Person Completing Checklist Date Completed

_____ _____
Printed Name and Title Phone Number

Exhibit 9.3b
Sample Letter: Referral Memorandum

[U.S. Postal Service Letterhead]

___[date]___
___[name]___, Inspector in Charge
___[street address]___
___[city, state, ZIP Code]___

SUBJECT: Federal Employees' Compensation Act (FECA) Claim Referral — Possible Fraud and/or Abuse

Name:_____

SSN:_____

File No: __[OWCP case number]_____

Dear ___[name]___:

This is in reference to the FECA Claim filed ___[name]___, ___[SSN]___, __[employing office]__.

It is requested that consideration be given to investigating this claim for possible fraud and/or abuse. Attached is a copy of the claim, the Fraud and Abuse Referral Checklist, and all pertinent documentation. As indicated by the attached, the basis for this request is __[basis of request]___.

Thank you for your attention regarding this matter. Please advise this office of your decision.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: Copy of Claim
Fraud and Abuse Checklist

10. Third Party Liability

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When a third party is involved in a job-related injury or illness...

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Common Circumstances for a Third Party Claim
10.2 Investigating the Potential Third Party Case . . . . . *ICCO*
10.3 Notifying the Employee and the Third Party of a Potential Third Party Claim . . . *ICCO*
10.4 Determining Whether DOL or the USPS Has Authority to Pursue Recovery of Damages . . . . . *ICCO*
Obligation: Noting Responsibility for Pursuing the Claim

DOL Authority

When DOL has authority to pursue recovery of damages...

10.5 Notifying OWCP of a Potential Third Party Claim . . . . . *ICCO*
10.6 Monitoring the Case . . . . . *ICCO*

USPS Authority

When the USPS has authority to pursue recovery of damages...

10.7 Keeping DOL Updated . . . . . *ICCO*
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When the employee wants to assign the claim to the USPS for recovery...

10.9 Deciding Whether to Accept Assignment . . . . . *ICCO*
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Factors in Deciding Whether to Accept Assignment
10.10 Pursuing Recovery of Damages . . . . . *ICCO*
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When the employee pursues third party action not represented by an attorney...

10.11 Notifying the Employee of the Government's Lien and Monitoring the Case . . . *ICCO*

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When the employee pursues third party action represented by an attorney...

10.12 Notifying the Attorney of the Government's Lien and Monitoring the Case . . . . . *ICCO*
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Employee Indecision or Failure

When the employee does not pursue third party action or is unsuccessful in the recovery attempt...

10.13 Deciding Whether to Seek Assignment . . . . . *ICCO*
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Settlement

When settlement has been made...

10.15 Disbursing Settlement Funds . . . . . *ICCO*

Records

When records are requested...

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When employees must be compensated for court appearances...

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10.3a Sample Letter: Notice to the Injured Employee of Potential Third Party Claim and Office of Workers' Compensation Programs Procedures
10.3b Sample Letter: Second Request for Form 2562, Notice of Potential Third Party Claim
10.3c Sample Letter: Notice to the Third Party of the Injury
10.5 Sample Letter: Notice to Office of Workers' Compensation Programs of Third Party Involvement
10.9a Sample Letter: Notice to the Employee of the U.S. Postal Service Decision Not to Accept Assignment and Information on Employee Options
10.9b Sample Letter: Notice to the Employee of the Postal Service Decision to Accept Assignment
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10.11c Sample Letter: Notice to the Employee of the Government's Lien and Request for Further Information

10.12a Sample Letter: Notice to the Attorney of the Government's Lien

10.12b Sample Letter: Request for Status and Transmission of Further Information

10.14 Sample Letter: Request for Information From the Employee and Notice to the Employee of the Government's Lien

10.15 Sample Letter: Memo to the U.S. Postal Service Disbursement Office Advising of Disbursement to Be Made

10. Third Party Liability

Overview

When a third party a person or organization other than the USPS or another U.S. agency is responsible for a job-related injury or illness for which an employee receives benefits under FECA, either DOL or the USPS may want to attempt to recover damages from the third party or the insurer.

Damages in this case means (1) what DOL is entitled to for wage compensation and medical and related benefits paid out and (2) what the employee is entitled to for pain, suffering, damage to property, and out-of-pocket expenses not covered by FECA benefits. Although USPS COP is not recoverable, the USPS gains from the recovery of DOL funds because the USPS liability to DOL is reduced by the amount recovered.

To serve the interests of the USPS, ICCO personnel need to do these things:

1. Identify potential third party cases and provide the initial investigation and documentation.
2. Assess the feasibility of attempting to recover damages by considering whether the third party is clearly at fault, how rapid recovery might be, and whether the payoff would be large enough to warrant the considerable effort involved.
3. If DOL has authority to pursue recovery (in cases of job-related illness and some job-related injury), identify the case for DOL, supply necessary documentation, request DOL to pursue the claim, and then monitor the case.
4. If the USPS has authority to pursue recovery, find out whether the employee will attempt to do this on his or her own behalf, with or without the aid of an attorney, or whether the employee will assign this task to the USPS. You will not want to accept assignment, of course, if you have determined that pursuit is not feasible. If it is feasible, continue this pursuit under the guidance of the area HR IC analyst.
5. Once a settlement is reached, make sure that settlement funds are disbursed properly between the employee and DOL.
6. Once the settlement funds are disbursed, make sure that OWCP credits the appropriate payment amount to the USPS.

Procedures

Potential Third Party Case

When a third party is involved in a job-related injury or illness...

10.1 Recognizing a Potential Third Party Case — *ICCO*

☐ Review CA-1 especially item 29 and the description of the accident in the case of traumatic injury, CA-2 in the case of occupational illness, or CA-5 or 5b in the case of death to determine if a third party is involved and whether that third party could be responsible for the injury, illness, or death and thus liable for the damages.

Common Circumstances for a Third Party Claim

Although a third party recovery case can arise from many circumstances in which a third party's act or failure to act results in the injury or death of an employee, the most common circumstances include, but are not limited to, these:

— Automobile accidents.

— Animal attacks.

— Tripping, slipping, and falling on sidewalks, steps, and other portions of nonfederal property.

— Defective machinery, automobiles, and equipment.

— Physical attacks and other assaults.

— Defects in leased postal premises.

10.2 Investigating the Potential Third Party Case — *ICCO*

☐ Coordinate an investigation of the incident resulting in injury or the circumstances of illness, doing the following:

— Review Form 1769, *Accident Report*, and CA-1, CA-2, CA-5, or CA-5b to determine if they are adequate to provide needed information and determine third party liability.

— If necessary and possible, obtain a detailed, written statement from:

– The injured employee.

– Any witness to the incident.

– Any other person who may be acquainted with the facts or is identified as having pertinent information.

— If necessary, obtain:

– The name, address, and telephone number of the third party.

– A detailed description of the place where the incident occurred and all the circumstances concerning the incident.

☐ If any further investigation of the incident has been made by the local police, USPS vehicle services, USPS safety personnel, the Inspection Service, or any other organization, obtain a copy of the reports and the investigative file.

SEE Handbook M-19, *Accident Investigation Tort Claims*, for information and procedures regarding investigative techniques and guides.

10.3 Notifying the Employee and the Third Party of a Potential Third Party Claim — *ICCO*

☐ When you have identified a potential third party case, provide the following to the injured employee and a copy to OWCP (updating HRIS):

— Notice to the Injured Employee of Potential Third Party Claim and OWCP Procedures (see Exhibit 10.3a for sample letter).

— Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim.*

Ask the employee to complete and return Form 2562 immediately.

☐ If you have not received the completed Form 2562 within 15 days, provide the injured employee (updating HRIS):

— Second Request, *Notice of Potential Third Party* for Claim Form 2562 (see Exhibit 10.3b).

Follow up as necessary to secure the completed form.

☐ Immediately send to the potential third party (updating HRIS):

— Notice to the Third Party of the Injury (see Exhibit 10.3c).

10.4 Determining Whether DOL or the USPS Has Authority to Pursue Recovery of Damages — *ICCO*

☐ Note whether DOL or the USPS is responsible for recovering damages.

Obligation: Noting Responsibility for Pursuing the Claim

FECA (5 U.S.C. 8131-2) provides that if an injury or death of an employee compensable under FECA is caused by a third party, DOL may require the employee receiving the benefits (or the beneficiary) to do one of the following:

1. Assign to the United States any right of action he or she may have (1) to force the third party to pay damages or (2) to share in money received in satisfaction of a liability claim.
2. Prosecute the action in his or her own name.

If the employee refuses to assign right of action to the United States or to prosecute an action in his or her own name when required to do so by the Secretary of Labor, he or she may be denied compensation by DOL.

An agreement between the director of OWCP, DOL, and the USPS (November 1980) provides that to more efficiently and effectively accomplish the stated purpose of FECA, OWCP agrees that the USPS may administratively pursue recovery of damages from the third party who is responsible for the injury sustained by a USPS employee in all cases of traumatic injury except in any of the following cases:

a. When the injury results in the death of the employee.
b. When the injury occurs outside of the United States or Canada.
c. When the third party is a common carrier.
d. When malpractice or product liability is involved.
e. When injuries are sustained by more than one employee in the same incident (group injuries).

Pursuit of recovery of damages in those cases and in occupational illness cases is the responsibility of DOL.

DOL Authority

When DOL has authority to pursue recovery of damages...

10.5 Notifying OWCP of a Potential Third Party Claim — *ICCO*

□ Send to OWCP, together with CA-1, CA-2, CA-5, or CA-5b (updating HRIS):

— Notice to OWCP of Third Party Involvement (see Exhibit 10.5).

— A copy of the completed Form 2562.

— The investigation report and other file material needed to support the case.

◇ *If the CA-1, CA-2, CA-5 or CA-5b has already been submitted to OWCP, forward these items as soon as possible. Do not delay submitting the CA-1, CA-2, CA-5 or CA-5b pending receipt of third party information.*

SEE 4.7, Submitting the Claim Package to OWCP.

10.6 Monitoring the Case — *ICCO*

- ☐ When DOL has authority, take no *direct* action to recover damages. When the claim clearly reflects a potential for high-dollar settlement, or when there is clear-cut liability and the possibility of a quick settlement, follow up to see that OWCP encourages the employee to initiate a claim, either with or without the aid of an attorney.
- ☐ Monitor the progress of OWCP's action and obtain periodic status reports until the case is closed.
- ☐ Refer to the area HR IC analyst any such cases that are closed without a payment from the third party.

USPS Authority

When the USPS has authority to pursue recovery of damages...

10.7 Keeping DOL Updated — *ICCO*

☐ Forward copies to OWCP of all letters issued together with other pertinent third party claim documents.

10.8 Determining Whether the Employee Intends to Pursue Third Party Action — *ICCO*

☐ On the basis of answers to Form 2562 and other information you have, determine whether the employee intends to pursue the claim and, if so, whether the employee is represented by an attorney.

USPS Pursuit of Recovery

When the employee wants to assign the claim to the USPS for recovery...

10.9 Deciding Whether to Accept Assignment — *ICCO*

☐ Decide whether it is feasible to pursue recovery of damages.

— If not, provide the employee:

– Notice to the Employee of the USPS Decision Not to Accept Assignment and Information on Employee Options (see Exhibit 10.9a).

— If so, provide the employee (updating HRIS):

– Notice to the Employee of the USPS Decision to Accept Assignment (see Exhibit 10.9b).

– Form 2577, *Assignment of Claim to the USPS*.

Obligation: Assuming Authority to Accept Assignment and Sign Release

The following are authorized to accept voluntary assignment of an employee's claim against a third party:

1. An area HR IC analyst.
2. A senior IC specialist.
3. An attorney from the Headquarters Claims Division of the Law Department.

A senior IC specialist can sign a release on behalf of the USPS before disbursement when requested by the third party or insurance carrier.

Factors in Deciding Whether to Accept Assignment

Negotiating third party settlements is a cumbersome process requiring coordination of efforts with the employee, third party, attorney, and insurance company, and completion of numerous forms and letters. This work load can be reduced by being selective in choosing third party cases for pursuit. The general premise is that workhours expended should result in significant dollar recovery.

◇ *Pursue a third party claim only when it clearly reflects a potential for high-dollar settlement or when there is clear-cut liability and the possibility of a quick settlement.*

10.10 Pursuing Recovery of Damages — *ICCO*

☐ When you receive assignment of the employee's claim on Form 2577, send to the third party and to his or her insurer, if known (updating HRIS):

— Notice to the Third Party of Assignment of the Postal Employee's Claim and Request for Settlement Discussion (see Exhibit 10.10a).

— A copy of the completed Form 2577.

☐ If you do not initially receive a reply to the notice to the third party of assignment of the claim to the USPS, follow up by sending to the third party and to his or her insurer, if known (updating HRIS):

— Request to the Third Party for Settlement (see Exhibit 10.10b).

A reasonable amount to request is three to five times the amount of the lien (see Exhibit 10.10c, Claim Negotiation, for information on computing the lien and projecting a settlement figure).

☐ When you receive a reply to the notice to the third party of assignment of the claim to the USPS (Exhibit 10.10a) or to the request for settlement (Exhibit 10.10b), attempt to negotiate a settlement of the government's and the employee's claim.

◇ *Contact the area HR IC analyst if you need assistance.*

SEE Exhibit 10.10c, Claim Negotiation.

Obligation: Recovering Damages When the Case Is Assigned to the USPS

When the employee has indicated that he or she does not wish to pursue a recovery from a third party and has assigned the claim to the USPS, the USPS with certain adjustments is entitled to recover from the third party or his or her insurer the compensation and medical and related expenses paid by DOL on behalf of the employee. In addition, the USPS is entitled to recover on behalf of the employee those damages to which the employee may be entitled. Such damages may consist of payment for pain and suffering sustained by the employee, any damage to the employee's personal property, and out-of-pocket expense not covered by FECA benefits.

☐ When you recover damages, provide the employee and the area HR IC analyst:

— A copy of Form 2556, which indicates the employee's total entitlement.

Make sure that OWCP district office is provided with copies of all documents pertaining to the recovery.

Employee Pursuit of Recovery

When the employee pursues third party action not represented by an attorney...

10.11 Notifying the Employee of the Government's Lien and Monitoring the Case — *ICCO*

☐ Furnish the employee (updating HRIS):

— Form 2557, *Employee's Third Party Recovery Statement*.

— Notice to the Employee of the Government's Lien (see Exhibit 10.11a).

☐ Mail to the third party and/or the insurer (updating HRIS):

— Notice to the Third Party and/or Insurer of the Government's Lien (see Exhibit 10.11b).

☐ Monitor the status of the case as necessary, sending periodic letters requesting status or action taken (updating HRIS):

— At least *every 60 days* after the notice of the government's lien is given to the employee, check with the employee to determine the status of the case. If necessary, send Notice to the Employee of the Government's Lien and Request for Further Information (see Exhibit 10.11c).

— If *within 6 months* after the accident a recovery has not been made, or if before that time there is information that the action on the claim has been terminated, contact the employee for the status of the recovery action.

☐ If the employee *decides not to pursue or is unsuccessful* in the recovery attempt, proceed in accordance with "When the employee does not pursue third party action or is unsuccessful in the recovery attempt...."

☐ When you receive notification from the postal employee that the case has been terminated:

— Obtain, verify, and correct if necessary the settlement sheet, Form 2557, *Employee's Third Party Recovery Statement*, and payment due the USPS.

— Forward settlement sheet in accordance with 10.15, Disbursing Settlement Funds.

☐ Provide the employee and the area HR IC analyst a copy of Form 2557, which indicates the employee's total entitlement. Ensure that OWCP district office is provided with copies of all documents pertaining to the recovery.

Attorney Pursuit of Recovery

When the employee pursues third party action represented by an attorney...

10.12 Notifying the Attorney of the Government's Lien and Monitoring the Case — *ICCO*

☐ Forward to the employee's attorney (updating HRIS):

— Form 2556, *Third Party Statement of Recovery.*

— Notice to the Attorney of the Government's Lien, together with the copies of pertinent reports referred to in that letter (see Exhibit 10.12a).

☐ Monitor the status of the case as necessary, sending periodic letters requesting status or action taken (updating HRIS):

— *Within 30 days* after mailing the notice of lien, send Request for Status and Transmission of Further Information (see Exhibit 10.12b) to the attorney who is representing the postal employee.

— *Within 90 days* after mailing the notice of lien and request for status, try to obtain a status report on the progress of the case by contacting the attorney directly. Continue to obtain status reports as frequently as necessary.

— *Within 90 days* after any request for a status report has been made, send a follow-up letter to the attorney.

— *Within 15 days* after the follow-up letter is sent, contact the employee regarding status of the case. If recovery still has not been made, do one of the following:

– Monitor progress if the case is still in the process of recovery.

– Send the case to the area HR IC analyst for further action.

☐ When you receive information that a third party recovery of damages is imminent, contact DOL for an up-to-date statement of all disbursements made by DOL and advise the employee or the employee's attorney of those disbursements.

Obligation: Recovering Damages that the USPS Is Entitled to Recover From Proceeds Paid to the Employee

The USPS, with certain adjustments, is entitled to recover from the proceeds paid to an employee by a third party the amount of compensation and medical and related expenses paid by DOL on behalf of the employee. COP monies *cannot* be recovered.

☐ When you receive notification from the postal employee's attorney that the case has been terminated:

— Without payment of any damages to the USPS:

– Verify the nature of termination and do one of the following:

– Attempt to obtain a voluntary assignment if the case appears to have merit.

- Close the file.

— By payment of damage to the employee:

- Obtain and verify the settlement sheet, Form 2556, *Third Party Statement of Recovery*, and payment due the USPS.
- Forward the settlement sheet to the appropriate USPS disbursement office in accordance with 10.15, Disbursing Settlement Funds.

☐ Provide the employee and the area HR IC analyst a copy of Form 2556, which indicates the employee's total entitlement. Ensure that OWCP district office is provided with copies of all documents pertaining to the recovery.

Employee Indecision or Failure

When the employee does not pursue third party action or is unsuccessful in the recovery attempt...

10.13 Deciding Whether to Seek Assignment — *ICCO*

☐ Decide whether it is feasible to pursue recovery of damages.

SEE 10.9, Deciding Whether to Accept Assignment.

10.14 Seeking Assignment of the Case to the USPS — *ICCO*

☐ Furnish the employee (updating HRIS):

— Form 2559, *Third Party Claim — Information Request*.

— Request for Information From the Employee and Notice to the Employee of the Government's Lien (see Exhibit 10.14).

☐ Seek resolution as necessary:

— If you do not receive Form 2559 *within 15 days*, contact the employee directly or through the employee's supervisor to determine what action the employee intends to take against the third party.

— If the employee advises:

– That he or she *will* seek recovery against the third party, proceed in accordance with "When the employee pursues third party action represented by an attorney..." or "When the employee pursues third party action not represented by an attorney...," as appropriate.

– That he or she *will not* seek recovery against the third party, or is unable to decide what action he or she will take, ask whether the employee will agree to assign his or her claim against the third party to the USPS by signing Form 2577, *Assignment of Claim to the USPS*.

— If the employee declines to make the assignment:

– Refrain from saying or doing anything to the employee that could be regarded as pressuring or coercing the employee to agreeing to the assignment.

– Point out that the USPS is not ordering or directing the employee to either sue or assign the claim, but advise the employee of the following information:

- By assigning a claim to the USPS, the employee will enable the USPS to attempt to shift the financial liability for the employee's injury from the USPS to the true wrongdoer, i.e., the third party.

- The ultimate recovery that the employee will realize for the injury cannot possibly be reduced by the employee's agreement to the assignment. An employee is entitled to a minimum of 20 percent of the net recovery after the expense of the recovery (attorney's fees, property damage, and court costs only) have been deducted. In addition, any surplus amount realized in the third party action that exceeds the amount of the employee's compensation payments and the expense of realization or collection will be paid to the employee.

- DOL is authorized to require pursuit or assignment of the claim and to terminate an employee's compensation payments if he or she refuses to pursue or assign what appears to be a valid third party claim.

— If the employee continues to refuse to pursue or assign his or her claim, then refer the file to the area HR IC analyst. Use Form 2560, *Referral of Third*

Party Material, to transmit the file. Take no further action to obtain an assignment after the file is referred.

Settlement

When settlement has been made...

10.15 Disbursing Settlement Funds — *ICCO*

☐ If the third party check is made payable to OWCP and includes only OWCP payment, send the check and Form 2556 or 2557, as applicable, directly to OWCP.

☐ If the check is made payable to the USPS:

— If it includes only OWCP payment, deposit the check and issue a Treasury check or no-fee money order to OWCP.

— If it includes OWCP payment with the employee's share, includes payments issued in installments, or is payable to the postmaster, the following procedures apply:

– Deposit the check or monies in the postmaster's trust account.

– Request a receipt Form 3544, *Post Office Receipt for Money*. Include the employee's name and OWCP claim number on the receipt.

– Together with Form 2556 or 2557, whichever is applicable, forward to the accounting office Memo to the USPS Disbursement Office Advising of Disbursement to Be Made (see Exhibit 10.15).

– Have the accounting office issue to the appropriate parties, i.e., OWCP and postal employee, no-fee money orders or Treasury checks that include the employee's name and OWCP claim number.

– If the third party makes installment payments, see that disbursements are issued to the postal employee at periodic intervals (3 or 6 months) until the total expected monies from the third party are collected.

SEE Appendix B, Addresses, for addresses of OWCP lockbox depositories.

Records

When records are requested...

SEE Chapter 12, Records Management.

Court Compensation

When employees must be compensated for court appearances...

SEE Chapter 13, Timekeeping and Accounting.

Exhibit 10.3a

Sample Letter: Notice to the Injured Employee of Potential Third Party Claim and Office of Workers' Compensation Programs Procedures

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Notice of Potential Third Party Claim
To:

File Number: ____[OWCP case number]_____

Date of Injury: _____

Our records show that on the above date you sustained an injury under circumstances that may place liability for damages upon a third party (a person or organization other than an employee or organization of the United States government).

Under the provisions of Title 5, United States Code, 8131, the Secretary of Labor can require a workers' compensation beneficiary to prosecute an action for damages in his or her own name when injury or death occurs under circumstances that indicate legal liability to pay damages on a party other than the government.

As a beneficiary of workers' compensation, you are asked to seek the recovery of damages from such a third party. When you recover damages, you will be entitled to keep a minimum of 20 percent of the net recovery, but out of the remainder of the damages recovered, you must reimburse the United States for any payments made to you.

Enclosed is Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim*. Kindly complete this form and return it in the self-addressed envelope provided. The USPS encourages you to pursue this claim in one of the following ways:

1. Retain an Attorney: Your own lawyer can usually obtain the best settlement. The required 20 percent and any other money remaining after payment of the attorney's fees and reimbursement of government expenses is yours to keep. To find a lawyer, you might check with your union steward or other postal employees. The state or local bar association will generally have a list for referral service in the yellow pages. Most attorneys will accept such a claim on a contingency basis; i.e., if no settlement is reached, they will not charge you.
2. Self Pursuit: You can pursue the claim yourself. To do this, contact the third party or that party's insurance company yourself and request a settlement. The amount of recovery is up to you, but you should take into consideration your obligation to reimburse the government for payments made to you or on your behalf. The required 20 percent and any other money remaining after reimbursement of government expenses is yours to keep.

3. USPS Assignment: If you have incurred medical expenses and you do not wish to pursue the claim using either of the above methods, you can assign your claim to the USPS. By doing so, you authorize the Injury Compensation Control Office to attempt to reach a settlement with the third party on your behalf. The required 20 percent and any other money remaining after reimbursement of government expenses is yours to keep. No fee is charged.

If, after considering the alternatives, you plan to pursue a third party claim, indicate on the Form 2562, section C, item 3, which of the three actions listed you intend to pursue. If you refuse to pursue the claim, the Department of Labor will be notified, and you may become ineligible for injury compensation.

Please return the Form 2562, whether or not you plan to pursue a third party claim, to our office within ___[7 to 14]___ days of the date of this letter. If you have any questions, you may contact our office at ___[ICCO telephone number]___.

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosure: Form 2562

cc: OWCP District Office
File

Exhibit 10.3b

Sample Letter: Second Request for Form 2562, *Notice of Potential Third Party Claim*

[U.S. Postal Service Letterhead]

Date:

Our Ref:

Subject: Second Request for Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim*

To:

File Number: ___[OWCP case number]_____

Date of Injury:_____

You are required to complete Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim*, and return it to the Injury Compensation Control Office as instructed in a previous memorandum.

The completed Form 2562 *must* be received by this office no later than ___[current date plus 7 days]___. Failure to respond or return this form by the date specified will result in further necessary action.

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: OWCP District Office
File

Exhibit 10.3c

Sample Letter: Notice to the Third Party of the Injury

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Employee: _____

Date of Injury: _____

Dear ___[name]___:

This letter is to give you notice that the above-named postal employee was injured under circumstances that indicate you may be legally liable. The circumstances are as follows:

[Describe circumstances.]

When we receive documentation of the extent of the injury, further action may be taken. This may come from the employee or a private attorney retained by the employee, or if the employee prefers, ___[he/she]___may assign ___[his/her]___ claim to this office for action.

Any claim will include special damages (medical bills, any personal property loss, etc.) and general damages (pain and suffering, inconvenience, etc.).

If you have any questions, you, your insurance company, or your attorney may call this office at ___[ICCO telephone number]___ for further information.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: OWCP District Office
File

Exhibit 10.5

Sample Letter: Notice to Office of Workers' Compensation Programs of Third Party Involvement

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Potential Third Party Claim
To: [applicable OWCP district office]

Employee: _____

File Number: ___[OWCP case number]_____

Date of Injury:_____

This memo is to give you notice that the above-named postal employee was injured under circumstances that indicate potential third party liability. The circumstances are as follows:

[Describe circumstances.]

As you know, under these circumstances, we do not have authority administratively to pursue collection of damages from the third party. Therefore, we request that your office pursue this matter and ensure that the U.S. Postal Service subrogation rights are protected.

Thank you for your cooperation.

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: File

Exhibit 10.9a

Sample Letter: Notice to the Employee of the U.S. Postal Service Decision Not to Accept Assignment and Information on Employee Options

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Third Party Claim
To:

File Number: ____[OWCP case number]_____

Date of Injury: _____

This memorandum acknowledges receipt of your completed Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim*, in which you indicate that you wish to assign your claim to the U.S. Postal Service. Based upon administrative considerations, we regretfully cannot accept an assignment at this time.

Accordingly, we encourage you to pursue your claim. As stated in our initial letter, you can pursue the claim yourself or retain the services of an attorney. In either case, we will be available for advice, guidance, and assistance.

If you have any questions, please contact the Injury Compensation Control Office at ___[ICCO telephone number]___.

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: File

Exhibit 10.9b

Sample Letter: Notice to the Employee of the Postal Service Decision to Accept Assignment

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Assignment of Claim to the USPS
To:

File Number: ___[OWCP case number]_____

Date of Injury:_____

This memorandum acknowledges receipt of your completed Form 2562, *Injury Compensation Program — Notice of Potential Third Party Claim*, in which you indicate that you wish to assign your claim to the U.S. Postal Service.

Please be advised that we will be happy to accept such an assignment. Accordingly, enclosed is Form 2577, *Assignment of Claim to the USPS.* Please sign and return the form immediately to this office in the self-addressed envelope provided for your convenience.

Since you have assigned your full personal injury claim to the Postal Service, it is extremely important that you not discuss the claim with the party responsible for your injury or with the party's insurance company or representative. If anyone questions you regarding this matter, please refer him or her to this office at ___[ICCO telephone number]___.

We believe that you are entitled to special damages (medical bills, personal property loss, and lost wages) and general damages (pain and suffering, inconvenience) for any injury suffered because of the negligence of another. We will do our best to see that any recovery is appropriate.

Thank you for your cooperation.

___[signature]___
___ [name]___
___[title]___
Injury Compensation Control Office

Enclosure: Form 2577

cc: File

Exhibit 10.10a

Sample Letter: Notice to the Third Party of Assignment of the Postal Employee's Claim and Request for Settlement Discussion

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Employee: _____

File Number: ____[OWCP case number]_____

Date of Injury:_____

Dear ___[name]___:

Recently you received a letter from this office stating that the above-named employee was injured when ___[he/she]___ __[brief description of injury circumstances]___.

According to the provisions of the Federal Employees' Compensation Act, our employee has filed for benefits and has assigned the personal injury claim to the Postal Service. A copy of that assignment, Form 2577, *Assignment of Claim to the USPS*, is attached.

We request that you, your insurance carrier, or your attorney contact this office at ___[ICCO telephone number]___ to discuss settlement of this matter.

Sincerely,

___[signature]___
___[name]____
___[title]___
Injury Compensation Control Office

Attachment: Copy of Form 2577

cc: File

Exhibit 10.10b

Sample Letter: Request to the Third Party for Settlement

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

File Number: ___[OWCP case number]_____

Date of Injury:_____

Dear ___[name]___:

On __[employee injury date]__, the above-named employee was injured under the following circumstances:

[Describe circumstances and third party involvement.]

We feel that you breached your legal duty to our employee by failing to ___[describe negligence of third party]___.

As stated in our previous letter, our employee assigned all rights to this personal injury claim to the Postal Service. As assignee, therefore, we have sole and full authority to handle this claim. Our authority flows from Title 5, United States Code, 8131–32; 20 *Code of Federal Regulations* 10.500, et seq.; and *4 Code of Federal Regulations* 102.2, et seq.

As we feel that there is liability, we present our claim for damages. We feel that a very reasonable value for our claim is $ __[amount]__. This represents special damages (out-of-pocket expenses such as medical expenses), with the remainder allocated to general damages (pain and suffering).

Again, we have the authority to settle this claim locally and would prefer to do so. Please contact me at ___[ICCO telephone number]___. Should you prefer to mail your check or money order (made payable to the U.S. Postal Service in the amount mentioned above), a postage-paid envelope is enclosed.

May we hear from you by ___[current date plus 14 days]___?

Thank you for your attention to this matter.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosure: Postage-paid envelope

cc: File

Exhibit 10.10c

Claim Negotiation

Negotiation Strategy

Factors to Consider

Both sides in a third party action are normally interested in settling the claim amicably and avoiding the inconvenience and expense of litigation. Essentially, injury compensation control office personnel and the representatives of the third party are trying to reach an agreement as to the value of the employee's injury with its attendant pain, suffering, and inconvenience for which there is no fixed price.

Whether the injury is major or minor depends on factors other than the medical or lost time expenses. These factors are:

— The severity of the injury.

— Whether permanent disfigurement resulted from the injury.

— Whether there is a possibility of long-term medical problems because of the injury. For example, the physician says the claimant will probably develop arthritis 5 to 10 years from now because of the injury.

Credibility

No single negotiating method is best. The correct technique is the one that works best for you. To be effective, however, you will need to establish and maintain credibility.

— Use terms of the trade to sound knowledgeable and to increase your confidence in yourself and your job. These include the following:

  – Legal terminology, such as negligence, tort, absolute liability, comparative negligence, contributory negligence.

  – Shorthand terminology familiar to the other party, such as "specials," "medicals," "med pay," "P.D." (property damage), "pain and suffering."

— Know your case. Review the complete file so that you know and can discuss:

  – All the details concerning the accident and the injury.

  – The legal basis for the claim (i.e., what the third party did or did not do and how this caused the injury).

  – The nature and extent of the employee's injury.

  – Special damages, including property damages, doctors' bills, hospital bills, prescriptions, other medical expenses, and lost earnings (even if wholly or partially compensated by Department of Labor (DOL) payments, annual or sick leave taken, or schedule award).

  – General damages, including pain, suffering, embarrassment, temporary and permanent limitation of use of part of the body, interference with the employee's normal activities (such as sports, hobbies, and home life).

Calculations

Be prepared with calculations to guide you:

— Figure the government's lien by adding up all costs for:
  – Compensation payments.
  – Medical bills and related expenses.
  – Any other employee out-of-pocket expenses.
— Compute a projected settlement figure by multiplying the total dollar amount of the lien by one of the following:
  – For a minor injury, three times the amount of the lien.
  – For a major injury, five times the amount of the lien.
  – For disfigurement cases, use DOL schedule, which pays a maximum of $3,500 for disfigurement of the face, head, or neck.

Conduct of Negotiations

Remember that it is in the best interest of the USPS to obtain the maximum settlement: the greater the settlement, the larger the surplus and a surplus is insurance against expenditures if the employee's injury recurs.

Try to get the third party representatives to make the first settlement offer. Occasionally, they will surprise you and offer more than the minimum you were prepared to accept.

Make high original settlement demands. The third party representatives will never offer to pay more than you demand. Normally, you can expect them at first to offer to pay nothing at all, or perhaps only the "out-of-pocket" expenses. If you start high and they start low, a settlement can usually be reached at an acceptable point in between. If your original demand is at or below a fair settlement amount, there is no room to negotiate.

Do not necessarily believe everything representatives of the other side say. They too will be trying to emphasize the facts and laws that are favorable to them and to gloss over matters that could increase the possibility of liability and the extent of the damages.

If at first it appears that a mutually satisfactory settlement cannot be reached, do not give up. To avoid litigation, both sides should be willing to give a little. If the parties are not very far apart after negotiation, impasses frequently can be resolved by "splitting the difference" — settling for an amount halfway between the lowest settlement demand and the highest settlement offer.

Common Questions From an Attorney or Adjuster

Q. *What right do you have to accept an assignment?*

A. Title 5, United States Code, 8131.

Q. *If the employee was aware of the hazard, why should we (the insurance company) pay?*

A. Awareness of a hazard by the employee does not provide a shield for the insurance company.

Q. *What pain and suffering?*

A. Have you ever sustained this type of injury? Have you ever experienced emotional trauma? How do you know the level of pain and suffering?

Q. *Your claim couldn't possibly be worth $3,000! How could it?*

A. You mean it is worth more? Your insured's dog is a monster. There may be permanent disfigurement. I handle numerous claims, and my request is reasonable.

Q. *What is your formula?*

A. There is no formula. Each case is evaluated and compared with other settlements.

Q. *Are you a lawyer?*

A. We are not the employee's legal representatives, but representatives of the USPS, which is an assignee of the claim.

Q. *How can you assign a personal injury claim?*

A. You can't under state law, but we are presenting this claim under federal law, 5 U.S.C. 8131, 8132.

Q. *Can we get a release from the injured employee even though the claim has been assigned to the USPS?*

A. Yes, but it is legally ineffective.

Q. *Your carrier crossed the lawn and fell. Therefore, there is no liability.*

A. Our carrier's status as invitee is not altered by crossing the lawn.

Q. *Your carrier failed to use the sidewalk and is negligent.*

A. Our carrier used reasonable care and is not required to use sidewalks.

Watch Your Language

Use simple sentences with nouns and active verbs.

– "The animal charged...."

Personalize. Use names.

– "...our letter carrier, Madeline Johnson."

Use specifics.

– "The beast caused a gash that required medical treatment and...."

Develop a convincing vocabulary:

— To describe the event:

charge	skulk	brutal	lunge
savage	ferocious	impale	slink
violent	pounce	onslaught	vicious

— To describe the injury:

cavity	groove	pierced	misery
stab	bruised	anguish	gash
excruciating	throbbing	slash	crushed
rip	ache	pain	raw

Important Points of Telephone Negotiating

— Caller Advantage
The caller is prepared and chooses the time of the call. You should offset this advantage by telling the adjuster that you will review the case and return his or her call.

— Risky
Telephone negotiating creates the temptation to settle too soon. Do not resolve on the first call and offer.

— Easy To Be Depersonalized
Do not be Uncle Sam versus Big Business. Remain a representative of the injured employee.

— Fast
Know what you want before you call or return a call: an offer, a counter offer, a statement of position? When you get the answer or information you want, get off the phone.

— Protection
When you encounter problems or become nervous, excuse yourself to take care of other business. Return the call when you are better prepared.

Summary

1. Be the caller.
2. Plan and prepare.
3. Have the file at hand.
4. Use credible words.
5. Listen and make a memo of the discussion for the file.
6. Remain courteous, calm, and cool. Always exit gracefully.
7. Write a letter in reference to the call, proposing the next action.

Exhibit 10.11a

Sample Letter: Notice to the Employee of the Government's Lien

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Notice to the Employee of the Government's Lien
To:

File Number: ___[OWCP case number]_____

Date of Injury:_____

Our records show that you have presented or you intend to present a claim for damages against a third party apparently responsible for your injury.

The Federal Employees' Compensation Act provides that the United States must be reimbursed out of any third party recovery for any disbursements made to you or on your behalf by the United States. Therefore, you should include as damages in your claim the disbursements indicated on the enclosed Form 2557, *Employee's Third Party Recovery Statement*, and any other disbursements that you have received or that have been made on your behalf. If you receive additional treatment, compensation, or continuation of pay, contact this office for an up-to-date statement of disbursement before settling your claim.

This office must be notified of any recovery you obtain. Completion and submission of the Form 2557 will serve as notification of a recovery obtained without the services of an attorney. It will also enable you to determine the amount of any refund you must pay to the Postal Service. A self-addressed return envelope is enclosed for your convenience.

If you retain the services of an attorney to assist you in your third party claim, please advise this office immediately and provide the attorney's name and complete address.

If you have not initiated a third party action or retained an attorney to represent you, we encourage you to consider assigning your claim to the U.S. Postal Service.

If you wish to discuss this matter or desire us to assist you, please contact our office at ___[ICCO telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosure: Form 2557

cc: OWCP District Office File

Exhibit 10.11b

Sample Letter: Notice to the Third Party and/or Insurer of the Government's Lien

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Employee: _____

File Number: ____[OWCP case number]____

Date of Injury: _____

Your Insurer: _____

Policy Number: _____

Dear ___[name]___:

We have been informed that the postal employee named above will make, or has made, a claim for damages as a result of an incident involving ___[you/your insurer]___ that occurred on the date shown.

The injury occurred in the performance of federal employment and comes under the Federal Employees' Compensation Act (Title 5, United States Code, 8108, et seq.). Section 8132 requires that the government be reimbursed for payments made to or on behalf of a beneficiary out of the recovery made from a third party. Section 8132, Adjustment After Recovery From a Third Person, also states:

> No court, insurer, attorney, or other person shall pay or distribute to the beneficiary or his designee the proceeds of such suit or settlement without first satisfying or assuring satisfaction of the interest of the United States.

Because of the government's financial interest in the outcome of this case, we request that you please request a statement from this office of the government's disbursements before distributing any proceeds in settlement of this case.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

cc: OWCP District Office

Exhibit 10.11c

Sample Letter: Notice to the Employee of the Government's Lien and Request for Further Information

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Notice of the Government's Lien and *Third Party Claim — Information Request*
To:

File Number: ___[OWCP case number]_____

Date of Injury:_____

This is a follow-up to our letter dated _____ regarding the third party claim that you plan to pursue on your own.

Under the provisions of Title 5, United States Code, 8131, the Secretary of Labor can require a workers' compensation beneficiary to prosecute an action for damages in his or her own name when injury or death occurs under circumstances that indicate a party other than the government has a legal liability to pay damages. As a beneficiary of workers' compensation, you were asked to seek the recovery of damages from such a third party. When you recover damages, you are entitled to keep a minimum of 20 percent of the net recovery, but out of the remainder of the damages recovered, you must reimburse the United States for any payments it has made to you.

If you have initiated a third party action, you should contact us for a statement of any Office of Workers' Compensation Programs (OWCP) disbursements made to you or on your behalf before you make a final settlement. These disbursements must be repaid from any recovery you make from the third party.

If you have reached a settlement, please submit a completed copy of the previously provided Form 2557 to this office. If you have not reached a settlement, please provide a statement for our records about whether, as a result of this injury, you have presented a claim for damages against anyone other than the Postal Service or OWCP. Please answer the questions on the enclosed Form 2559, *Third Party Claim — Information Request*, and return it promptly to this office.

If you wish to discuss this matter or desire to have us assist you, please contact the Injury Compensation Control Office at ___[ICCO telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosure: Form 2559

cc: OWCP District Office
File

Exhibit 10.12a

Sample Letter: Notice to the Attorney of the Government's Lien

[U.S. Postal Service Letterhead]

___[date]___
___[name]___ , Attorney-at-Law
___[street address]___
___[city, state, ZIP Code]___

Employee: _____

File Number: ____[OWCP case number]____

Date of Injury: _____

Dear ___[name]___:

We have been advised that you have been retained to represent the above-named employee with respect to the third party damage claim arising for the above-referenced injury. Copies of the reports contained in our file are enclosed for your information. If disbursements have been made in this case, you will also find a statement showing the disbursements made to date.

Title 5, United States Code, 8132 states, in part:

> No court, insurer, attorney or other person shall pay or distribute to the beneficiary or his designee the proceeds of such suit or settlement without first satisfying or assuring satisfaction of the interest of the United States.

Also, enclosed is Form 2556, *Third Party Statement of Recovery*, for your use. Upon request, we will furnish you an updated statement of disbursements or copies of additional reports.

If you have any questions concerning the third party aspect of this case, or the obligation and responsibilities to protect the government's lien imposed by Title 5, United States Code, 8131, please contact the Injury Compensation Control Office at ___[ICCO telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosures: Form 2556
Attorney Information Sheet
Case File Copies
List of Disbursements

cc: OWCP District Office
File

THIRD PARTY CASE ATTORNEY INFORMATION SHEET

The purpose of this enclosure is to provide you with specific information that you may not be aware of as to the implications of the Federal Workers' Compensation Laws.

1. Assistance that the USPS ___[Injury Compensation Control Office]___ can provide:

   Although most of our records and investigations are not public information, all information available will be forwarded to you upon request since you represent our employee.

2. Lien against any recovery:

   We have a lien upon any recovery; the exact amount of the lien depends upon the results of certain computations. Specials that our lien may comprise are medical bills, schedule awards, and compensation benefits. An update of these specials can be obtained upon request. This lien is against any recovery, regardless of whether it is for special and/or general damages.

3. Basis of the federal lien:

   Our lien is based upon Title 5, United States Code, 8132, which indicates, in part:

   If an injury for which FECA compensation is payable is caused under circumstances creating a legal liability in a person other than the United States to pay damages, and the employee receives money in satisfaction of that liability, after deducting the costs of suit and a reasonable attorney's fee, the employee shall refund to the United States the amount of compensation paid by the United States and credit any surplus or future payments of compensation payable for the same injury.

4. Statement of recovery:

   We are providing a Form 2556, *Statement of Recovery*. If and when a settlement is made, this statement of recovery must be completed. Full instructions for completion are on the reverse of the form; however, if you need any additional information or assistance, please call this office.

5. How to compute the amount of the federal lien:

   Form 2556, *Third Party Statement of Recovery*, is used to compute the amount of the lien and of the employee's recovery. Our lien is not the total amount of our expenses; we allow a deduction to the employee for the payment of attorney fees. This allowance for attorney's fees goes to the employee.

6. Satisfaction of lien:

   Please ensure that our lien is satisfied before distributing any recovery. Federal law prohibits the distribution of a recovery without first ensuring satisfaction of the lien.

Exhibit 10.12b

Sample Letter: Request for Status and Transmission of Further Information

[U.S. Postal Service Letterhead]

___[date]___
___[name]___, Attorney-at-Law
___[street address]___
___[city, state, ZIP Code]___

Employee: _____

File Number: ____[OWCP case number]____

Date of Injury: _____

Dear ___[name]___:

We will appreciate a report concerning the present status of this third party damage claim. If possible, advise us of the date that you expect the matter to be concluded.

We are enclosing copies of additional reports from our file that may be of assistance to you. Also, enclosed is a statement of the disbursements made to the employee.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosures: Additional Reports
Statement of Disbursements

cc: OWCP District Office
File

Exhibit 10.14

Sample Letter: Request for Information From the Employee and Notice to the Employee of the Government's Lien

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Third Party Claim — Information Request
To:

File Number: ___[OWCP case number]_____

Date of Injury:_____

We have received information from you that you do not intend to take action against the third party in your on-the-job injury claim.

Please be advised that under the provisions of Title 5, United States Code, 8131, the Secretary of Labor can require a workers' compensation beneficiary to prosecute an action for damages in his or her own name when injury or death occurs under circumstances that indicate a party other than the government has a legal liability to pay damages . As a beneficiary of workers' compensation, you were asked to seek the recovery of damages from such a third party. When you recover damages, you are entitled to keep a minimum of 20 percent of the net recovery, but out of the remainder of the damages recovered, you must reimburse the United States for any payments made to you.

If you refuse to pursue your claim or assign it to the U.S. Postal Service, the U.S. Department of Labor, Office of Workers' Compensation, may deny your compensation benefits. Please answer the questions on the enclosed Form 2559, *Third Party Claim — Information Request*, for our records and promptly return it to this office in the self-addressed envelope provided.

In the event that you have initiated a third party action, you should contact us for a statement of Office of Workers' Compensation Programs disbursements made to you or on your behalf before you make a final settlement. These disbursements must be repaid from any recovery you make from the third party.

If you wish to discuss this matter or desire us to assist you, please contact our office at ___[ICCO telephone number]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Control Office

Enclosure: Form 2559

cc: OWCP District Office File

Exhibit 10.15

Sample Letter: Memo to the U.S. Postal Service Disbursement Office Advising of Disbursement to Be Made

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Recovery Disbursements — Third Party Settlement
To: Disbursing Officer
___[applicable account office]___

The enclosed check or money order in the amount of $ ___[amount]___ represents settlement of a third party claim for:

Name:

SSN:

OWCP Case No:

These funds are forwarded for disposition (see attached Form 2556 or 2557 for amount of total recovery).

1. Amount due Office of Workers' Compensation Programs $ ___[amount]_____

   Send check to:

   U.S. Department of Labor

   [Applicable District Office] Lockbox Depository

2. Amount due employee $ ___[amount]_____

   Send check to:

   ___[employee's name]___

   c/o Injury Compensation Control Office

___[signature]___
Injury Compensation Control Office

11. Rehabilitation Program

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11.8a Sample Modified Job Description

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11.11b Sample Form 50 Actions (continued)

11.11b Sample Form 50 Actions (continued)

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11.16a Sample Letter: Post-reemployment or Reassignment Employee Interview

11.16b Sample Post-reemployment or Reassignment Supervisor Interview

11.21 Sample Letter: Termination of Limited Duty Assignment for Refusal of In-House Rehabilitation Program Job Offer

11. Rehabilitation Program

Overview

The Joint DOL-USPS Rehabilitation Program was developed to fulfill the USPS legal obligation to provide work for injured-on-duty (IOD) employees. Providing gainful employment within medically defined work restrictions has proven to be in the best interest of both the employee and the USPS. In many cases, returning to work has aided the employee in reaching maximum recovery. This program is also one of the most viable means of controlling workers' compensation costs.

Over the years, an in-house rehabilitation program has evolved and has been incorporated into the Rehabilitation Program as a means of facilitating the proper placement and accommodation of current employees with permanent partial disabilities resulting from injuries on duty. This program is also appropriate for reassigning to permanent modified positions employees who have not received compensation but have been in temporary limited duty assignments for an extended period of time.

From December 1978 to May 1979, DOL and the USPS conducted a pilot program for the rehabilitation of injured USPS workers through reemployment. From that pilot program, procedures and forms were developed that provided the basis for the original guidelines issued in October 1979 and for Handbook EL-515, *Joint Rehabilitation Guidelines* (issued in May 1992), now being made a part of this handbook. The Rehabilitation Program is applicable for both former and current USPS employees on OWCP rolls.

To be eligible for participation in the Rehabilitation Program, the employee must meet the following criteria:

— He or she must have an approved FECA claim on file with OWCP.

— He or she must have a job-related, permanent partial disability documented by medical evidence.

— He or she must be receiving or be eligible to receive compensation payments for the disability. (Note that an employee working in a limited duty assignment is *eligible* for disability compensation but is *not receiving* it because an appropriate limited duty assignment has been made available.)

Procedures

Potential Rehabilitation Candidates

When you review chargeback reports each accounting period...

Obligation: Recognizing OWCP and USPS Responsibilities

It is the administrative responsibility of the Secretary of Labor, pursuant to Title 5, United States Code, Chapter 81, to direct the rehabilitation efforts of those permanently disabled individuals covered under FECA. OWCP, Employment Standards Administration, DOL, administers those responsibilities at the discretion of the Secretary.

The USPS responsibility is outlined in FECA, 8151(b)(2). It is the policy of the USPS to make every effort to reemploy or reassign IOD employees with permanent partial disabilities to positions consistent with their medical work restrictions.

11.1 Identifying Potential Rehabilitation Program Participants — *area IC personnel*

OWCP Pay Statuses

Regular-periodic-roll (PR) status applies to both current and former employees who have been medically determined to be totally disabled for an extended or indefinite period.

No wage-earning-capacity (PN) status applies to employees who have been determined to be totally and permanently disabled.

☐ Identify possible participants by doing the following:

— Review periodic roll reports and prioritize these employees according to their potential for termination or reduction of compensation in the following target groups:

  – 49 years old and under — injured less than 5 years.
  – 49 years old and under — injured more than 5 years.
  – 50–60 years old — regardless of injury date.
  – 61 years old and over — regardless of injury date.

— Review the most current medical documents for both PR- and PN-status employees in the order of the priority target groups mentioned.

- If OWCP has previously screened a PR-status case for possible Rehabilitation Program participation, wait at least 1 year before submitting another request, unless new evidence indicating a change in duty status has been received.
- Compare current documents with previous medical reports to determine if there is any change in the employee's duty status.

— Consider for reemployment individuals who were separated on the basis of unsatisfactory attendance if the periods of absenteeism were deemed compensable by OWCP. *Do not, however, refer former employees who have been separated because of serious misconduct (e.g., mail theft).*

◇ *While a PN status indicates that the employee will never be able to return to work in any capacity, it must be remembered that conditions can and do change. The medical status, therefore, should be reviewed periodically.*

SEE Section 4.26, Considering a Former or Current Employee for Reemployment

SEE Exhibit 11.1, OWCP's Role in Referring Employees to the Rehabilitation Program.

11.2 Requesting Referral From OWCP — *area IC personnel or IC specialist*

☐ After potential Rehabilitation Program participants have been identified, contact OWCP district director to review the PR and PN cases to determine the feasibility of Rehabilitation Program participation and prepare a referral package. The request should include the names of the employees and their corresponding OWCP file numbers.

☐ Enter HRIS call-up for OWCP response (see Exhibit 11.1, OWCP's Role in Referring Employees to the Rehabilitation Program).

☐ Maintain contact with OWCP rehabilitation specialist or counselor assigned to the case. After the official referral is made to the USPS, OWCP rehabilitation counselor will contact the ICCO within 3 weeks to determine if the package has been received and to discuss the case.

Request OWCP rehabilitation specialist's or counselor's assistance to obtain and clarify any missing or conflicting documentation. Continued coordination between the ICCO and OWCP rehabilitation specialist or counselor will result in a successful Rehabilitation Program effort in most instances.

11.3 Responding to the Referral Package Received From OWCP — *area IC personnel or IC specialist*

☐ Upon receiving the referral package from OWCP, review it to ensure completeness and timeliness of all medical documentation, and to ensure that the package contains the following items:

— OWCP-3, *Injured Worker's Rehabilitation Status Report* (see Exhibit 11.1, OWCP's Role in Referring Employees to the Rehabilitation Program).

— OWCP-5a, b, or c, Work Capacity Evaluation, and the medical report.

— OWCP-9, *Rehabilitation Case Record.*

— OWCP-35, *Routine Referral and Award.*

◇ *All medical documentation must be based on a medical examination conducted within 1 year of the date of the referral.*

☐ Enter the information into HRIS.

☐ Within 5 days of receiving the referral, review the employee's OPF located in the personnel services office to identify major elements of the employee's work history.

☐ If the OPF has been retired to the Federal Records Center, submit an SF–127, *Request for Official Personnel Folder (Separated Employee)*, in duplicate, to:

NATIONAL PERSONNEL RECORDS CENTER (CIVILIAN)
GENERAL SERVICE ADMINISTRATION
111 WINNEBAGO
ST LOUIS MO 63118-4199

The request generally takes about 2 weeks for processing. Upon receiving the OPF, review and document the rehabilitation file as indicated above.

☐ Retrieve and review the employee's injury compensation case file, normally located in the ICCO, for the accepted conditions and diagnoses of record.

☐ If the former employee has relocated, send a copy of the rehabilitation file to the appropriate ICCO. When the former employee relocates to an area outside the geographic area of the originating ICCO, the senior IC specialist must send all pertinent rehabilitation documents, via transmittal letter, to the gaining ICCO that has jurisdiction where the former employee has relocated (see Section 11.13, Initiating a Job Offer for a Relocated Injured Employee). (ELM 546.143)

☐ Based on review of the referral package and the employee's previous work history, determine whether to:

— Recommend a refusal to reemploy with justification (see Section 11.6, Initiating Management Refusal Action, for refusal procedures).

— Pursue the rehabilitation effort (see Section 11.7, Identifying a Modified Job Assignment).

Medical Evaluation

When medical evaluation is necessary...

11.4 Evaluating the Results of Medical Examinations— *associate area medical director or contract medical provider*

Evaluation of OWCP Rehabilitation Program Referrals

The USPS medical provider will evaluate all medical records referred by OWCP.

An injured employee may have some degree of concurrent disability not caused by or related to the original job injury or disability. The USPS medical provider will carefully evaluate all concurrent disabilities and include their potential impact in his or her recommendation. Concurrent disabilities must be accommodated in job offers under the Rehabilitation Program.

As with other after-duty examinations, consultative services may be used if deemed appropriate by the USPS medical provider.

The medical officer concurs with OWCP-documented medical limitations or provides an opinion increasing the employee's limitations in a separate report. The medical officer cannot lessen the medical limitations rendered by OWCP in any way.

The job assignment is made on the basis of OWCP-documented medical limitation.

SEE Chapter 6, Medical Management.

The Pre-reemployment or Reassignment Medical Examination

Before job offers can be extended, employees may undergo a complete physical examination by the USPS. This examination is paid for by the USPS and is in addition to medical documentation submitted by OWCP. In medically contested cases where OWCP has conducted a second opinion and/or impartial medical examination, it would not be necessary.

☐ Initiate a pre-reemployment or reassignment medical examination by doing the following:

— Schedule an appointment with the USPS contract medical provider.

— Advise the USPS contract medical provider, in writing, that the employee is being considered for reemployment or reassignment under the Rehabilitation Program and provide copies of all medical records provided by OWCP (see Exhibit 11.4a, Sample Letter: Task Force Review Letter). Submit these documents in advance of the scheduled examination date.

☐ Issue a letter to the employee advising him or her to report for the scheduled medical examination (see Exhibit 11.4b, Sample Letter: Employee Scheduling for Pre-reemployment/Reassignment Medical Examination). Prepare the letter for the signature of the district HR manager or designee. It is encouraged that two copies of the letter be sent by both regular and certified mail with return receipt requested. Provide copies to OWCP rehabilitation specialist, rehabilitation counselor, and the claims examiner. The letter should include the following:

- The reason for the examination.
- The date, time, and location of the examination.
- A statement indicating the employee's right to bring updated medical documents.
- A statement indicating possible consequences if the employee fails to appear for the examination.

☐ Use HRIS call-up to follow up.

☐ If the employee fails to appear for the pre-reemployment or reassignment medical examination, do one of the following:

- If there is an acceptable reason for the employee's failure to appear (e.g., family emergency), reschedule the examination.
- If the excuse is unacceptable, contact the claims examiner immediately, both by phone and in writing, for appropriate follow-up from OWCP.

11.5 Responding to the Results of the Medical Examination — *area IC personnel or ICCO*

Results of Medical Examination

Results of the pre-reemployment or reassignment medical examination are documented on Form 2485, *Medical Examination and Assessment*. The USPS contract medical provider also completes Form 2489, *Identification of Physical/Mental Disability*, at this time.

☐ After the USPS contract medical provider forwards a copy of Form 2485 and Form 2489 and any consultative reports to the ICCO, evaluate the results of the examination to determine if a job offer can be made.

☐ If the results of the medical examination indicate any of the following situations, proceed to initiate a management refusal action (see Section 11.6, Initiating Management Refusal Action):

— The injured employee's restrictions are so severe that a suitable USPS assignment cannot be identified. Most restrictions can be accommodated within the USPS. Some limitations, however, prohibit accommodation in a USPS environment.

— The medical evidence indicates that the injured employee is no longer disabled because of residuals from the job-related injury. The current disability has been caused by a nonoccupational condition.

◇ *In cases where the injured employee is not eligible for participation in the Rehabilitation Program, continued entitlement to compensation benefits may also be in question.*

☐ If the results of the USPS medical examination confirm that the employee is permanently partially disabled because of a job-related injury and capable of performing restricted duties, proceed to identify a modified job assignment (see Section 11.7, Identifying a Modified Job Assignment).

◇ *Maintain close contact with the functional managers or supervisors to identify a suitable modified assignment, as it is the most critical and often the most difficult step in the Rehabilitation Program process.*

Management Refusal

When management refuses to provide a modified job offer...

11.6 Initiating Management Refusal Action — *senior IC specialist or district HR manager*

☐ When it is determined that management will not extend a job offer, prepare a letter to the Headquarters manager of Safety and Risk Management (see Exhibit 11.6a, Sample Letter: Request for Concurrence on a Management Refusal). The letter must be signed by the district manager and a copy sent through the appropriate functional manager (the manager of function where the employee was assigned at time of injury) and the designated area HR analyst, and must include the following:

— The specific reasons for the proposed management refusal.

— Supporting medical evidence and other documentation.

— A request for Headquarters' concurrence with the proposed action.

☐ Upon receipt of Headquarters' concurrence, initiate the following:

— Notify the injured employee, in writing, that while he or she was considered for placement under the Rehabilitation Program, a job offer will not be extended, and the reasons why.

— Provide a copy of this letter to OWCP rehabilitation specialist and rehabilitation counselor. Prepare a cover letter that includes the following:

– A summary of actions taken.

– A request for consideration of appropriate action, e.g.:

- Pursuance of placement with a new employer.

- Issuance of a loss of wage-earning capacity (LWEC) decision, as appropriate, if further rehabilitation efforts are unsuccessful (see Exhibit 11.6b, Loss of Wage-Earning Capacity). This request should be addressed by the claims examiner.

- Termination of compensation payments when medical evidence indicates disability is not because of the job-related condition.

– Copies of Headquarters' concurrence.

– Employee's notification letter.

– Supporting documentation.

SEE Chapter 8, Controversion and Challenge.

Management Job Offer

When management identifies a modified job offer...

Identification of Modified Job Assignments

Determining the procedure to be used to facilitate assignment identification is a local management decision. The following two processes are common practices:

— Management contact by placement priority.

This procedure calls for the ICCO to contact the appropriate management level on a person-to-person basis.

While this method usually results in the development of a suitable assignment, it can be extremely time consuming, delay the entire process, and create an unnecessary amount of correspondence. If the manager of the office where the employee was officially assigned at the time of injury cannot identify a permanent modified assignment within that office, the ICCO must proceed to the next management level until an assignment is identified or all avenues are exhausted.

— Management team.

In this process, management designates representatives from major functions or work units to serve on a Rehabilitation Program committee chaired by the senior IC specialist. Medical restrictions of potential program participants are reviewed, placement priorities are considered, and recommended assignments are drafted. Following the meeting, the senior IC specialist submits the recommended modified assignment to the appropriate manager for concurrence.

The management team method has proven to be very successful. It allows for immediate input from the major functional areas, availability of the senior IC specialist to answer questions and clarify responsibilities, and a timely rehabilitation process.

11.7 Identifying a Modified Job Assignment — *ICCO*

☐ Initiate the following actions:

— Prepare a memorandum for the appropriate management review (see Exhibit 11.7a, Sample Letter: Request for Identification of Rehabilitation Position) that includes the following information:

– Notification that the employee is being considered for permanent placement under the Rehabilitation Program.

– A request that a modified assignment be identified.

– A brief work history of the employee.

– The employee's medical restrictions.

– Priority placement guidelines (see Exhibit 11.7b, Rehabilitation Assignment Priority). Placement priority for the Rehabilitation Program is the same as for limited duty.

— Submit the prepared memorandum to the locally determined review authority.

☐ Assist management in identifying a suitable modified job assignment. Review the injured employee's medically defined work restrictions. Each task within the identified assignment must comply with the employee's medical limitation. Consider the following possible placements:

— *Employee's current position*. If the employee is a current employee (was never separated from the USPS rolls) and is capable of performing his or her core duties with only minor modification, assignment to the current position may be feasible. This type of accommodation is not considered a modified assignment, and the workhours are charged to the regular operation LDC.

— *Reassignment to an existing position*. If a current employee can no longer perform the core duties of his or her position but is capable of performing the core duties of another authorized position for which he or she is qualified, reassignment may be offered. Since the employee is performing the core duties of the position, the workhours are charged to the regular operation LDC.

— *Residual vacancy*. If a vacancy has been posted for bid or application and there are no successful bidders or applicants, both current and former employees may be offered a residual vacancy if they can perform the core duties of the position with only minor modification. Again, since the core duties are being performed, this is not considered a modified assignment and the workhours are charged to the regular operation LDC.

— *Modified assignment*. If a current or former employee's restrictions prohibit accommodation as described in the categories above, individual tasks must be identified and combined to develop a modified assignment consistent with the employee's medical restrictions. These tasks are usually subfunctions and may be from multiple positions. The workhours for employees accommodated in modified assignments are charged to LDC 69.

☐ Ensure that:

— Any adverse or disruptive influence on the employee is minimized (see Exhibit 11.7b, Rehabilitation Assignment Priority).

— Contractual obligations are honored (see Exhibit 11.7c, Contractual Obligations for Rehabilitation Positions).

11.8 Preparing the Job Description — *area IC personnel or ICCO*

☐ Once a suitable assignment has been identified, develop a concise job description that is clear and readily understandable.

Do not use a standard position description with annotations to reflect the accommodations unless the employee's work restrictions are so minor that they can be accommodated in a regular assignment. (For example, a letter carrier can perform his or her regular job with the use of a cart.)

Include the following elements:

— *The name of the injured employee cited on the job description*. This demonstrates that the assignment was specifically tailored to accommodate the injured employee's medical limitations.

— *The job title.* Choose a job title to indicate a modified assignment and state what the employee's status will be (for example, Clerk, Distribution (Modified), Full-Time Regular).

— *The work schedule, tour, and location*.

— *All specific tasks involved in the assignment*. Avoid terms such as "other duties as assigned." If such terms are used, however, give examples of what the "other duties" are.

— *The physical requirements of the proposed tasks.* Blanket statements such as "all assigned duties are within the defined medical restrictions" are not acceptable.

— *Any special workload demands or unusual working conditions.*

SEE Exhibit 11.8a, Sample Modified Job Description.

☐ Request the employee's treating physician or the ruling medical authority identified by OWCP to review the modified job description and provide his or her opinion about whether the identified tasks comply with the employee's medical restrictions (see Exhibit 11.8b, Request for Medical Review of Proposed Job Description).

Contact OWCP rehabilitation specialist and request that he or she assists in expediting the request.

— When the ruling authority is the employee's treating physician, contact him or her directly.

— When the ruling authority is a physician contracted by OWCP, the review request by OWCP must be made by either the rehabilitation specialist, the rehabilitation counselor, or the claims examiner.

◇ *When review by the physician who provided the work restrictions is not feasible, ensure that the USPS contract medical provider reviews the proposed job description.*

☐ In those instances when the reviewing physician determines that the job description should be modified, make the necessary changes to the job description before the actual job offer is made.

□ Once the proposed job description has been finalized, prepare (but do not yet send) a job offer letter that includes the following:

— The offered position title.

— The work schedule and tour.

— The work location.

— The grade and salary.

— The effective date of job availability.

— A description of the appropriate appeal rights.

— The date that a response to the job offer is required (usually 2 weeks from date of receipt).

— The possible consequences of refusing the offered job.

— A space designated for the employee's acceptance or refusal and comments.

◇ *Do not include any information regarding election of OPM benefits.*

SEE Section 4.26, Considering a Former or Current Employee for Reemployment

SEE Exhibit 11.8c, Sample Letter: Rehabilitation Program Job Offer.

11.9 Conducting the Pre-reemployment or Reassignment Interview With the Employee — *ICCO*

☐ Schedule a pre-reemployment or reassignment interview with the employee and do the following:

— Send a certified letter, with return receipt requested, to the employee approximately 2 weeks before the scheduled interview, requesting him or her to report for a pre-reemployment or reassignment interview (see Exhibit 11.9a, Sample Letter: Employee Scheduling for Pre-reemployment/ Reassignment Interview). Provide a copy to OWCP rehabilitation specialist and OWCP rehabilitation counselor or the staff nurse, if appropriate, and request their presence, depending upon availability, at the interview.

— Invite the following individuals to attend the interview so they are available to respond to the concerns of the employee:

– Representatives from the personnel services office and Labor Relations.

– The manager or supervisor of the proposed work site.

◇ *Whether or not the above individuals need to attend the interview depends on how much the designated ICCO person knows about these functional area matters.*

☐ If the employee fails to appear or provide an acceptable reason for not appearing, advise the rehabilitation specialist and request him or her to initiate appropriate follow-up action.

☐ Ensure that the employee receives the following information during the pre-employment interview (see Exhibit 11.9b, Pre-reemployment/Reassignment Employee Interview Checklist):

— An in-depth analysis of his or her medical limitations and his or her responsibility to work within the prescribed work restrictions.

— A full explanation of all restoration rights and benefits (see Exhibit 11.9c, Restoration Rights and Benefits). (A copy can be provided to the employee.)

— If applicable, the status of injury compensation, disability retirement benefits, and future eligibility (see Exhibit 11.9d, Retirement Considerations).

— All details regarding the identified assignment, including title, grade, salary, duties, work location, tour of duty and all other pertinent information. If applicable, indicate that the job description was reviewed by a physician, and state the doctor’s name and findings.

— Instructions for completion and submission of any required employment forms.

11.10 Extending the Job Offer — *area IC personnel or ICCO*

☐ Within 90 days of the official referral by the rehabilitation specialist (normally during the pre-reemployment interview), provide the employee with a written job offer package that includes the following:

— The job offer letter (see Exhibit 11.8c, Sample Letter: Rehabilitation Program Job Offer).

— The prepared job description (see Exhibit 11.8a, Sample Modified Job Description). *Without the job description the offer is invalid*.

Allow the employee 2 weeks to respond to the package.

◇ *If the job offer cannot be extended within 90 days because of unusual circumstances, the senior IC specialist must notify the rehabilitation specialist in writing before the 90th day with a copy to the area HR analyst of the reasons for the delay and the expected date it is encouraged that the job offer be sent by both regular and certified, return receipt mail.*

☐ Prepare a summary of the pre-reemployment interview and send it along with a copy of the job offer to both the rehabilitation specialist and the claims examiner at the time it is provided to the employee.

Good Faith Understanding

In the rehabilitation effort, both the employee and the USPS are expected to act in good faith. The USPS acts in good faith by offering an appropriate job to the employee within 90 days of the official referral by the rehabilitation specialist.

The employee acts in good faith by being flexible and realistic about the job being offered.

The rehabilitation specialist is responsible for monitoring the case relative to the good faith effort of both parties.

11.11 Responding to the Employee's Acceptance of the Job Offer — *ICCO*

☐ Upon receipt of the employee's acceptance, issue a letter to the employee advising him or her where, when, and to whom he or she is to report (see Exhibit 11.11a, Sample Letter: Employee Report to Duty).

Direction of the Employee Back to Work

When an employee returns to work, the ICCO person will accompany the employee to the appropriate office. If this is not practical, direct the employee as indicated below or as established by local protocol.

In reemployment cases, when the employee was a former employee who was previously separated from USPS rolls, the employee will normally be directed to report initially to the personnel services office for completion of the appropriate paperwork.

In reassignment cases, when the employee is a current employee who was never separated from USPS rolls, the employee may be directed to the work site. Personnel can usually process the appropriate paperwork without the employee's presence.

☐ Provide copies of the report-to-duty letter to the following individuals or units:

— *Personnel services office.* The local personnel services office has the administrative responsibility to complete all standard personnel forms including those required for health benefits insurance, life insurance, and retirement. Forward with a transmittal letter a copy of the report-to-duty letter requesting processing of the necessary paperwork. In addition to the report-to-duty letter, provide also:

  – Form 2489, *Identification of Physical/Mental Disability*, completed by the USPS contract medical provider. Information from this form is entered onto Form 50. (Do not retain a copy of Form 2489 in the Rehabilitation Program file.)

  – A copy of the prepared job description and the job offer and acceptance letter.

  – A copy of the appropriate sample, Exhibit 11.11b, Sample Forms 50 Actions

— *The manager or supervisor at the identified work site.* Provide also a copy of the job description and the job offer and acceptance letter. It is imperative that the manager or supervisor be advised of any change in the employee's status or work restrictions.

— *OWCP rehabilitation specialist or rehabilitation counselor.* Provide also a copy, along with copy of employee's acceptance.

— *OWCP claims examiner.* Provide also a copy of the employee's acceptance and a completed CA-3, *Report of Termination of Disability and/or Payment,* upon the employee's actual return to work.

☐ Coordinate with the personnel services office to ensure that OPM is notified of the reemployment of a disability annuitant previously approved for as annuity, even in cases where it was waived in lieu of OWCP benefits (see Exhibit 11.11c, OPM Notification of Reemployment of a Disability Annuitant).

— The reemployed individual's name.

— Social Security number.

— Date of birth.

— Civil service annuity claim number (CSA — civil service account).

— Date of reemployment.

— Indication of whether retirement deductions are to be made from the salary or the position to which reemployed.

A copy of Form 2485, *Medical Examination and Assessment*, must be attached.

The notification should be sent to:

RETIREMENT OPERATIONS CENTER
OFFICE OF PERSONNEL MANAGEMENT
PO BOX 45
BRYERS PA 16017-0045

SEE Exhibit 11.9d, Retirement Considerations.

☐ Enter call-up dates into HRIS for periodic follow-up actions.

11.12 Responding to the Employee's Refusal of, or Refusal to Respond to, the Job Offer — *area IC personnel or ICCO*

Obligation: Recognizing the Penalty of Refusing Work

Section 8106 of FECA provides that an employee who refuses to seek suitable work or refuses or neglects to work after suitable work is offered is not entitled to compensation.

☐ If the employee refuses the job offer, notify the rehabilitation specialist by telephone.

☐ Within 2 working days, advise the claims examiner, in writing, of the employee's refusal to accept the offered assignment, and send a copy to OWCP rehabilitation specialist. The following is to be attached to the advisement letter:

— A copy of the job offer and refusal letter signed by the employee.

— A copy of the pre-reemployment interview summary.

☐ Ensure that the offered assignment remains available during the entire OWCP due process procedure, which may result in a decision to terminate benefits.

◇ *The employee must be allowed to return to work if he or she accepts the job offer any time before the final OWCP due process action (i.e., issuance of decision to terminate benefits). This requirement is extremely important. If for any reason the offered assignment becomes unavailable before the conclusion of this process (e.g., assignment given to someone else, premature administrative action, etc.), or the offered position is deemed invalid by OWCP, the employee's entitlement to compensation payments will continue, and the entire rehabilitation effort is voided.*

OWCP Due Process

The OWCP claims examiner is provided with a copy of the job offer and job description at the same time it is extended to the employee. If the employee refuses the offer, a series of actions must take place to ensure that the injured employee receives due process as a result of a USPS offer of employment. These actions include the following:

— The claims examiner reviews the offer package, along with the evidence of record, and determines if it is suitable to the employee's partially disabled condition.

— When the offered job is determined not to be suitable, the claims examiner advises the ICCO, OWCP rehabilitation specialist, and the employee, in writing, of the unsuitability of the offer.

— When the claims examiner determines that the offered job is suitable, the claims examiner notifies the employee in writing of the following points:

- That OWCP considers the job offer suitable under the provisions of 5 U.S.C. 8106(c).
- That if the employee refuses the job, he or she will not be entitled to monetary benefits (except medical benefits) unless he or she can show that such refusal was reasonable or justified. The employee has 30 days from the date of the notification by the claims examiner to accept the employment or to explain why the employment was refused.
- That the offered job remains available for due process consideration.
- That the employee is entitled to LWEC, if applicable.
- That the employee can still accept the job without penalty.
- That further action will be taken without additional notice by OWCP for the employee's failure to cooperate.

— When the employee does not provide good cause for refusing the offered job, the claims examiner may terminate the employee's benefits at the end of the 30-day notification period in addition to 15 days for due process consideration.

SEE Exhibit 11.6b, Loss of Wage-Earning Capacity.

☐ When the claims examiner determines that the offered job was not suitable, coordinate with the appropriate manager or supervisor to make the necessary revisions and reoffer the job. This action will be considered a new job offer and, if refused, the employee will again be entitled to full due process.

Employee Relocation

When an injured employee has relocated to another geographical area subsequent to a job-related disability...

Obligation: Extending a Job Offer to a Relocated Employee

If a *current* employee voluntarily moves to another area, a job offer should be extended by the originating district first. As long as the employee is on USPS rolls and was not required to move, he or she should be available to return to work at his or her employing district.

If a *former* employee voluntarily moves to an isolated area that has limited job opportunities, a reasonable attempt should be made to reemploy the individual at a USPS facility within the commuting distance of his or her current address. However, if an assignment cannot be identified, the originating installation may make a suitable job offer.

If a *current or former* injured employee is required to move to a different geographic area because of health conditions that were caused by the injury, or that predated it, the issue of job availability must be considered with respect to the new area of residence.

It is USPS policy for the affected districts to act in a cooperative manner in meeting USPS obligations and achieving USPS objectives.

11.13 Initiating a Job Offer for a Relocated Injured Former Employee — *originating district's senior IC specialist*

☐ When a *former* employee has relocated to an area outside the geographic boundaries of the employing district, within 5 days of receipt of OWCP referral, send pertinent rehabilitation information with a cover letter, by certified mail with return receipt requested, to the senior IC specialist of the gaining district (the district where the employee now resides) requesting assistance in placing the employee. Provide a copy of the letter to the designated area HR analyst.

☐ Update the HRIS.

◇ *Contact the designated area HR analyst if assistance is required.*

11.14 Identifying a Modified Position for *Current* or *Former* Employees Who Have Relocated for Health Conditions — *area IC personnel or senior IC specialist*

☐ For current or former employees who have relocated for health conditions, make a good faith effort to identify a suitable assignment within commuting distance of the employee's new residence.

☐ Once a modified position is identified, continue the rehabilitation effort following standard procedures, keeping the originating district advised of the rehabilitation effort status.

◇ *Contact the designated area HR analyst if assistance is required.*

11.15 Arranging for Payment of Relocation Expenses — *senior IC specialist*

Obligation: Receiving Payment or Reimbursement of Moving Expenses

20 CFR 10.123(f) provides that an injured employee who relocates to accept a suitable job offer after termination from the USPS rolls may be entitled to receive payment or reimbursement of moving expenses from OWCP compensation fund. This provision further states that federal travel regulations pertaining to permanent change of duty station moves are to be used in determining whether expenses claimed are reasonable and necessary. (See FECA PM 2-813.14 for additional information.)

Relocation Expenses

Relocation expenses are payable only to former employees (no longer on postal rolls). When paid by OWCP, these expenses are paid from the compensation fund and charged back to the USPS along with all other compensable payments.

There is nothing in FECA or OWCP procedures that prohibits the employing district from paying or reimbursing the employee out of USPS funds under normal relocation procedures without requesting reimbursement from OWCP.

OWCP Responsibility

— OWCP adjudicates all requests for relocation. When the job offer is determined suitable and relocation is approved, OWCP senior claims examiner should notify the concerned parties of the procedures to obtain reimbursement.

— OWCP district office pays or reimburses authorized expenses except where the USPS has requested an advance payment from OWCP compensation fund.

— OWCP national office handles all requests for advance payment from the compensation fund in cases where the USPS cannot advance the money for the move from its own accounts.

Employee Responsibility

General Services Administration (GSA) regulations require that an employee whose moving expenses are paid by the federal government must remain in federal employment for one year after the move. If the employee ceases work for a reason unacceptable to OWCP, the relocation expenses will be declared an overpayment.

☐ Incorporate a positive statement in the job offer concerning payment of relocation expenses, forward a copy of the job description to OWCP claims examiner requesting a suitability determination before extending the job offer.

- ☐ Advise a potential Rehabilitation Program participant who has relocated that his or her relocation expenses will be paid as long as the offered assignment is found suitable by OWCP. Advise him or her of GSA regulations requiring continued employment for 1 year.
- ☐ Coordinate with Finance to ensure the following:
  - — Upon acceptance of the job offer, Finance, in coordination with the ICCO, will initiate required relocation actions, e.g., arrange for a government bill of lading to have a moving company transport the employee's household goods, issue advance payments, etc.
  - — Upon completion of the move, Finance will examine the expenditures and certify that the types of expenses and actual amounts are allowable according to GSA travel regulations, and in accordance with what the USPS would authorize for any other employee undergoing a permanent change of duty station. Copies of the certified bills and travel vouchers are then sent to OWCP for payment.
  - — If the employee ceases to work for a reason unacceptable to OWCP, Finance will declare the relocation expenses as overpayment.

Employee Return to Work

When the employee returns to work...

11.16 Monitoring the Injured Employee's Return to Work — *ICCO or employee's supervisor*

☐ Brief the immediate supervisor on the injured employee's medical status and work limitations.

☐ Conduct periodic follow-ups in coordination with OWCP to assist in the employee's readjustment to a working environment, to ensure that the employee is working safely within the prescribed work restrictions, and to identify potential problems. As a means of follow-up, the following actions are encouraged:

— *On the day the employee returns to work*, accompany the employee to his or her designated office or work site. When this is not possible, do the following:

– Contact the office to which the employee is to report before the reporting time. Remind the appropriate person of the employee's reporting time and request that the ICCO be called if there is any problem.

– Contact the employee and the supervisor later in the day to see if there are any potential concerns or problems. Let the employee know that the ICCO is available if he or she has questions regarding the assignment, work restriction, or claim. Advise the employee that routine employee matters must be handled through his or her supervisor or the local personnel services office.

— *At the end of the first week*, interview the employee and supervisor to evaluate the employee's adjustment to the work environment, the status of his or her physical well being, etc. (see Exhibit 11.16a, Sample Letter: Post-Reemployment/Reassignment Employee Interview, and Exhibit 11.16b, Sample Letter: Post-Reemployment/Reassignment Supervisor Interview).

— *At the end of the first month*, schedule the employee for a follow-up FFD, if necessary, to determine his or her medical condition during the adjustment period. The FFD findings may reveal that the employee's work restrictions need to be further modified on either a temporary or permanent basis. It is not unusual for an employee's work limitations to be temporarily more restrictive during the initial return-to-work period.

— Coordinate with the appropriate manager or supervisor and make the recommended modification to the work restrictions. Make any changes in writing and provide a copy to the employee, supervisor, OWCP rehabilitation specialist, and claims examiner.

— *At the end of the third and sixth months*, interview the employee and the supervisor to determine adjustment progress.

◇ *If the modification is permanent and restrictive to a degree that it prohibits the employee from performing the assigned tasks, a new job description will need to be developed.*

☐ Make additional contacts depending on the individual circumstances. If everything appears to be going well, further contacts are not necessary.

☐ Document progress reports based on the follow-up actions listed above and make them part of the employee's rehabilitation file. Provide copies of the reports to the rehabilitation specialist and the area HR analyst through normal management channels.

OWCP Rehabilitation Specialist Required Follow-Up

In coordinating efforts with the ICCO when conducting employee follow-ups, OWCP rehabilitation specialist or counselor has the responsibility to review the employee's progress for a minimum of 2 months following the return to work. If a rehabilitation nurse worked with the employee and the USPS in coordinating the RTW effort, the nurse contacts the employee for 2 months at the following intervals:

— The day the employee returns to work.

— The end of the first month.

— The end of the second month.

Follow-ups may continue beyond 2 months if:

— The employee still has adjustment problems.

— The employee is expected to increase from part-time to full-time employment.

— The rehabilitation specialist, as documented on OWCP-3 *Injured Worker's Rehabilitation Status Report*, believes that continued follow-up is necessary for the employee to remain successfully employed.

☐ To ensure the best interest of both the employee and the USPS, monitor the employee's progress as long as the employee remains in the Rehabilitation Program.

In many cases, after injured employees return to work under the Rehabilitation Program, their medical conditions improve to a point where they can successfully bid on positions for which they meet the physical requirements. In other cases, full recovery occurs over a period of time and the employees return to their former (or equivalent) positions.

1-Year Follow-Up

When the employee has been back to work for 1 year...

11.17 Scheduling and Monitoring the Results of a Follow-Up FFD — *ICCO or postal contract physician*

☐ Upon completion of the employee's first year in an assignment under the Rehabilitation Program, and continuing on an annual basis, ask the postal contract physician to review current medical information from the employee's treating physician. If the contract physician determines that a FFD is warranted, based on a change in medical conditions, then schedule the employee for the FFD to determine if there has been any change in the employee's condition and if the assignment needs to be adjusted or changed.

◇ *It is in the best interest of all concerned to motivate injured employees to perform at their full capabilities. When medically feasible, the progressive upgrading of assigned duties has been proven to help employees reach maximum recovery levels.*

☐ After the FFD has been conducted, provide the employee's supervisor or manager and OWCP claims examiner a copy of the FFD results in writing.

☐ If the FFD indicates *no change in the employee's work limitations*, advise the employee, in writing, of the FFD findings and the fact that his or her rehabilitation assignment will remain the same.

☐ If the results of the FFD indicate that the employee's *work limitations should be further restricted*, take the following actions:

— If the further restriction is slight and does not affect the performance of the assigned tasks, advise the employee of the fact that the specified work limitation has been further restricted, the degree of restriction, and the fact that the new restriction does not affect his or her current assignment.

— If the further restriction is significant and necessitates either a revision in the current assignment or the development of a new job description, consult the employee's supervisor and revise the current assignment to conform with the new restrictions. Advise the employee of the following:

  – That his or her work limitations have been further restricted (cite the degree of restriction).

  – That because the restrictions are considered permanent and may hinder the performance of the current position, a new job description will be developed, and upon finalization, a formal job offer will be extended pending OWCP's approval.

  – That, in the interim, his or her current assignment has been adjusted to meet the new work restrictions.

Since the previously offered and accepted assignment no longer complies with the employee's work limitations, and therefore is no longer a valid job offer, proceed with developing a new job description. Because the employee is already in a work status with the USPS, follow the procedures outlined in the next section (see *USPS In-House Rehabilitation Program).*

☐ When the results of the FFD indicate the employee's condition has improved to the extent that the *work limitations may be* reduced, initiate the following action:

— If the FFD indicates the employee is still permanently partially disabled from the job-related injury but is capable of a higher level of performance than that required in the current assignment, notify the ICCO to proceed with the in-house Rehabilitation Program procedures as outlined in the next section and advise the employee of the following:

– The FFD findings and the new restrictions.

– That a new job description is being developed to conform with his or her updated work restrictions and that upon finalization, a formal offer will be extended pending OWCP's approval.

– That, in the interim, he or she will remain in the current assignment because his or her work restrictions are well within the requirements of the current assignment.

— If the FFD indicates that the employee has improved and is capable of performing the full duties of the position held at the time of injury, the ICCO will proceed with appropriate restoration action as outlined below.

USPS In-House Rehabilitation Program

When an employee's disability is deemed to be permanent...

Obligation: Providing Rehabilitation for the Permanently Disabled Beneficiary

Section 8104 of FECA provides that the Secretary of Labor may direct a permanently disabled beneficiary under FECA to undergo vocational rehabilitation, and may furnish services from the Employee's Compensation Fund. The worker is entitled to compensation at the total disability rate while in a Rehabilitation Program.

OWCP Vocational Rehabilitation Services

Reemployed workers may voluntarily request vocational rehabilitation services offered by OWCP to keep them competitive in the labor market. Since it is USPS policy to make injured employees whole with regard to salary upon their return to work, USPS rehabilitation participants are not normally considered for these services.

The workers who are eligible include those holding the following:

— The positions with substantial loss of wage-earning capacity.

— The positions that will be reduced due to labor market trends.

— The positions with skill levels offering temporary employment.

— The positions that are made available to an experienced employee now able to perform only limited duties. These positions are especially tailored to the injured worker and would not available competitively at entry level. These positions with specific duties and salaries could probably not be duplicated in the general labor market.

Criteria for receiving these services are as follows:

— The rehabilitation services authorized by OWCP are initiated within 3 months of return to work and occur during nonworkhours.

— The employee's interest and ability to handle part-time rehabilitation services in addition to the regular work assignment must be considered.

— The Rehabilitation Program can be completed within 2 years.

In-House Rehabilitation Program

For the most part, the in-house program process is the same as that outlined in the previous section. Although this is considered an "in-house" program, FECA provisions and OWCP procedures are still applicable. OWCP is still the final authority in determining job suitability and compensation entitlement.

11.18 Identifying Potential In-House Program Participants — *ICCO*

☐ Identify potential participants by reviewing routine and requested medical reports from the treating physician, e.g., CA-17, narrative reports, etc. Once a determination of permanent disability is made, the temporary limited duty assignment is no longer appropriate and a permanent accommodation is required. When reviewing the reports, ascertain whether the employee's treating physician has done the following:

- — Determined that the employee's partial disability is permanent.
- — Failed to provide an anticipated recovery date or declared the disability to be permanent after the employee has been working in a limited duty capacity for an extended period, e.g., 1 year.
- — Repeatedly changed the anticipated recovery date of an employee who has been working in a limited duty capacity for an extended period.

SEE Chapter 6, Medical Management.

11.19 Scheduling and Monitoring the Results of the FFD to Determine If a Job Offer Can Be Made — *area IC personnel or ICCO*

☐ When a potential in-house program participant has been identified, first check OWCP case file for current medical information. If OWCP case file does not contain current or adequate medical information, then schedule the employee for an FFD (see Section 11.17, Scheduling and Monitoring the Results of a Follow-Up FFD). Require that the examination include a consultative examination by an appropriate board-certified specialist.

◇ *In instances where OWCP work restrictions are not current, it is imperative that the FFD be as thorough as possible. A consultation by a specialist is particularly important when there is a difference of medical opinion between the employee's treating physician and the USPS contract medical provider.*

☐ When the employee fails to appear for the FFD for an acceptable reason (such as a family emergency), reschedule the examination. If the excuse is unacceptable, seek guidance from Labor Relations.

☐ When the FFD has been conducted, ensure that the USPS contract medical provider provides the ICCO with the results of the FFD using by Form 2485.

☐ Determine whether to extend a job offer by reviewing the FFD results. If the FFD indicates that the employee is no longer disabled from the job-related injury (or has returned to his or her preinjury state), a permanent reassignment under the in-house Rehabilitation Program is not appropriate. In this instance, initiate the following actions:

— If the FFD finding is in conflict with the employee's treating physician:

– Request the USPS medical provider to identify the conflict and outline suggested course of actions with the ICCO personnel.

– Allow the employee to remain in his or her limited duty assignment until the matter is resolved. (At this point, all that exists is a difference in opinion between the USPS examining physicians and the employee's treating physician, which is not a sufficient reason to relieve an employee of his or her limited duty assignment.)

– If the difference in opinion cannot be resolved (ELM 547.34), prepare a challenge package and request OWCP to schedule a second opinion and independent medical examination.

– Upon receipt of OWCP's decision, take appropriate action such as the following:

- Direct the employee to return to his or her regular position.
- Advise the employee of his or her right to apply for a nonoccupational light-duty assignment under contractual provisions.
- Proceed with the in-house rehabilitation effort if it is determined that the employee does have permanent residual effects from the job-related injury.

— If the FFD is in agreement with the treating physician or the conflict has been resolved, proceed with an in-house rehabilitation effort.

SEE Exhibit 11.7c, Contractual Obligations for Rehabilitation Positions.
Chapter 6, Medical Management.
Chapter 8, Controversion and Challenge.

11.20 Extending an In-House Rehabilitation Job Offer — *ICCO*

☐ When a job offer can be made, proceed with the rehabilitation effort as outlined (see Section 11.5, Responding to the Results of the Medical Examination, through Section 11.10, Extending the Job Offer), except where OWCP involvement or notification is cited. Normally, there is no OWCP participation during the job identification through job offer process of the “in-house” program.

SEE Exhibit 11.7b, Rehabilitation Assignment Priority.

11.21 Responding to the Employee's Refusal of the In-House Rehabilitation Job Offer — *ICCO*

☐ When the injured employee refuses the job offer, prepare a letter for the signature of the district HR manager with a copy to the appropriate functional manager, advising the employee or designee of the following:

- — That because his or her disabilities have been determined to be permanent, he or she is no longer eligible for a limited duty assignment.
- — That he or she may still accept the offered assignment, which will remain open until OWCP determines its suitability and gives due process.
- — That OWCP will be advised that a permanent assignment was offered in good faith and rejected by the employee.
- — That the employee will remain in his or her limited duty assignment until OWCP makes a suitability determination on the rehabilitation job offer.

SEE Exhibit 11.21, Sample Letter: Termination of Limited Duty Assignment for Refusal of In-House Rehabilitation Program Job Offer.

☐ Advise management against any premature personnel action.

OWCP has the sole authority in determining if a job offer is valid. Additionally, under FECA provisions, the employee must be provided with another opportunity to accept the offer. Keep the offered position available until a final decision is made by OWCP (see Section 11.12, Responding to the Employee's Refusal of, or Refusal to Respond to, the Job Offer, for information concerning OWCP's due process).

☐ Send a complete package to OWCP claims examiner consisting of the following:

- — A summary letter of the actions taken.
- — The job offer and refusal.
- — The job description.
- — Supporting medical documentation.
- — The employee notification letter.

☐ If OWCP determines that the rehabilitation job offer is suitable, the employee is no longer entitled to limited duty. If the employee still refuses an in-house rehabilitation job offer after due process has been provided, terminate the limited duty assignment and direct the employee to personnel services office for other options available.

11.22 Responding to the Employee's Acceptance of the In-House Rehabilitation Job Offer — *ICCO*

☐ When the employee accepts the job, initiate appropriate notification as outlined in 11.11, Responding to the Employee's Acceptance of the Job Offer.

In addition to sending a copy of the employee's report-to-duty letter, provide OWCP with a complete package that includes copies of the following:

— Job offer and acceptance.

— Job description.

— Supporting medical documentation.

— Report-to-duty letter.

11.23 Responding to the Injured Employee's Return to Work — *ICCO*

☐ When the injured employee assumes the new permanent assignment, monitor the employee's work and medical progress and initiate follow-up action as cited in 11.16, Monitoring the Injured Employee's Return to Work.

Exhibit 11.1

Office of Workers' Compensation Program's Role in Referring Employees to the Rehabilitation Program

The Office of Workers' Compensation Programs (OWCP) rehabilitation specialist has the overall managerial responsibility for developing and screening referrals of injured employees from all sources. In addition, private or state rehabilitation counselors acting as screeners (OWCP RC-Ss) in a contractual arrangement with OWCP may screen and evaluate referrals of employees and perform initial interviews. In addition to requests received from ICCOs, the rehabilitation specialist (RS) may identify possible program participants from other sources, such as the claims examiner (CE), computer-generated referral lists, health professionals, the injured employee, unions, or attorneys.

Screening

Once the employee has been identified as a possible participant, the RS or the OWCP RC-S screens the compensation file to review basic information regarding the employee's medical condition, physical capabilities, reemployment potential, and other data that will determine the course of the rehabilitation effort.

Within 5 days of receipt of the files, the RS sends an OWCP-3, *Rehabilitation Status Report*, indicating the actions planned for the employee. Copies of OWCP-3 are sent to the appropriate parties, including those cited below, for information:

— Designated area HR analyst. (The area HR analyst should furnish a copy to the senior IC specialist.)

— Injured employee and representative, if any.

— OWCP compensation file.

Initial Employee Contact

The RS or OWCP RC-S contacts an eligible employee by mail or telephone to arrange an initial interview to discuss rehabilitation services and explain reemployment. The RS or OWCP RC-S uses an OWCP-6, *Initial Interview Letter*, soliciting personal or phone contact. If the employee does not respond to the OWCP-6 within 21 days:

— The RS notifies the CE of the employee's noncooperation and requests the CE to take appropriate action. The first action of the CE is to send an OWCP-11, *Notification of Due Process for Failure to Cooperate,* to the employee.

— If the employee fails to respond to the notification letter within 30 days, the CE reduces compensation benefits to $0 until the employee agrees to cooperate.

Interview With the Employee

The RS or OWCP RC-S conducts an interview with each employee by personal visit or telephone. The interview precedes any other services.

The quality of the initial interview depends on the ability of the RS or OWCP RC-S to communicate professional competence, a sense of urgency, and concern to the employee. The RS or OWCP RC-S must be able to listen effectively and ensure the following elements:

— The employee must be given an opportunity to express his or her feelings and other concerns that may interfere with the recovery process.

— The RS or OWCP RC-S must analyze and summarize the interview and clarify the rehabilitation process.

— The purpose of rehabilitation (i.e., to help a person get back to work) must be explained.

— The RS or OWCP RC-S stresses that training may not necessarily be included in the Rehabilitation Program.

— If the employee was previously approved for annuity by OPM, the RS advises the employee to contact the personnel services office for an explanation on the effects of reemployment on retirement benefits (see Exhibit 11.9d, Retirement Considerations).

— The RS or OWCP RC-S secures additional information, if needed, from the employee and discusses the next step in the rehabilitation process.

Determining Appropriate Action

Following the interview, services are either initiated to prepare the employee for a return to work, or are deferred, pending receipt of further medical or other information.

Usually, a rehabilitation counselor is assigned to facilitate the process; however, in some cases, a registered field nurse may be assigned by OWCP staff nurse to facilitate the medical management of the case.

OWCP Nurse Intervention Program

OWCP currently has a staff nurse assigned to each district office. When an injured employee has been in COP for 45 days, the CE automatically refers the case to the staff nurse for assignment to a field nurse to provide rehabilitation services within a 180-day period. The field nurse coordinates medical services and clarifies medical issues and obtains work restrictions. The injured employee is not required to participate in rehabilitation with the staff nurse. If the injured employee refuses such services, OWCP procedures call for the case to be referred back to the RS, where participation is mandatory.

Contact With Agency

Once work limitations are identified, the field nurse contacts the injured employee. The nurse will contact USPS district IC personnel to discuss identification of a modified job to accommodate the work restrictions. Ideally the field nurse meets with the IC personnel on site to identify possible job assignments for the injured employee.

If the claim file does not contain a current work restriction evaluation and a report of a medical evaluation conducted within the past year, the RS, OWCP RC-S, or staff nurse will notify the CE. The CE will obtain these documents before an official referral is made to the USPS.

SEE Chapter 6, Medical Management.

Closure of Referral Action

The RS or OWCP RC-S closes a referral by annotating the appropriate block of the OWCP-3, citing the reason for closure, and providing copies to all interested parties when rehabilitation services are considered inappropriate in the following cases:

— If unsuccessful attempts have been made to contact the employee (referred back to the CE).

— If the employee has already successfully returned to work with the USPS (e.g., limited duty).

— If the claim files have been previously referred to the RS or OWCP RC-S and there is no change from the previous condition.

— If the employee is permanently restricted to working less than 2 hours per day.

— If medical documentation does not indicate the employee can return to work at this time (referred back to the CE).

If the employee refuses to cooperate in recommended reemployment efforts, the RS or OWCP RC-S will take the following steps:

— If current medical information indicates that the employee can work at least 4 hours per day, the RS or OWCP RC-S informs the employee of the pertinent section of the Act.

  Section 8113(b) states that “if an individual without good cause fails to apply for and undergo vocational rehabilitation” and “the wage-earning capacity of the individual would probably have substantially increased,” the Secretary may reduce compensation. Furthermore, Section 8106(c) states that “a partially disabled employee who refuses to seek suitable work or refuses or neglects to work after suitable work is offered to, procured by, or secured for him, is not entitled to compensation.”

— If the employee persists in refusing to participate, the RS completes an OWCP-3, *Injured Worker’s Rehabilitation Status Report,* detailing the employee’s failure to cooperate, recommends to the CE that compensation

be reduced to $0, and closes the referral action. A copy of OWCP-3 is provided to the CE, and he or she then evaluates the employee's refusal and takes appropriate action.

Referral to a Rehabilitation Counselor by OWCP Rehabilitation Specialist

The OWCP RC is directed by the RS to provide rehabilitation services throughout the reemployment process and prepare monthly progress reports.

Initially, counseling and guidance focus on preparing the employee and easing the transition in returning to work, because frequently the employee has been away from work for a long time. There is usually a need to share concerns about the injury, the pain resulting from the injury, feelings about the loss of the preinjury job, and concerns about adjustment to work. The OWCP RC also provides the employee with information on benefits if a loss of salary occurs when accepting a new job.

Counseling services are continued after the employee returns to work to ensure that the employee has adjusted to the work environment.

In the rare instances when the RS performs these services directly with the employee, the RS is responsible for all those duties normally provided by the OWCP RC, such as counseling and guidance, coordination with the appropriate ICCO staff person, and follow-up.

The RS refers the employee to an OWCP RC through OWCP-35, *Routine Referral and Award*, which authorizes counseling, guidance, testing, and placement services by the OWCP RC. This form authorizes services for a specified dollar amount for up to 2 years of service unless the RS modifies the limit. Other documents in the referral package include:

— OWCP-3, *Injured Worker's Rehabilitation Status Report*.

— OWCP-5a, b, or c, *Work Capacity Evaluation,* with most current work restrictions.

— OWCP-9, *Rehabilitation Case Record*.

— Significant medical reports.

Actions Taken by OWCP Rehabilitation Counselor

The OWCP RC performs the following tasks:

— Meets with the employee, listens to his or her concerns, provides an understanding of the reemployment process, and ensures that the employee is prepared for return to work.

— Explains the purpose and process of reemployment or reassignment to the employee's treating physician, if needed.

— Ensures that current medical reports and work restrictions, if needed, are obtained from the treating physician. If there is a medical report from a second opinion specialist or impartial specialist, the CE determines which report carries the weight of medical evidence.

- — Evaluates the feasibility of the employee's reemployment based on all information available.
- — Recommends any additional services to assist in proper reemployment.
- — Coordinates with the ICCO and the RS and discusses any major obstacles to reemployment with the RS.
- — Facilitates the employee's transition back to work through open and objective communication with all parties involved with the employee.
- — Serves as a liaison between employee's treating physician and the USPS in developing a rehabilitation job.
- — Evaluates the suitability of the proposed job offer before the pre-reemployment interview of the employee.

Referral to the USPS

When it is determined that the employee is a candidate for participation in the rehabilitation program, the RS sends a referral package to the area IC office or the ICCO at the originating installation. An OWCP-3 is used as the official referral for reemployment or reassignment under the rehabilitation program. The case is considered referred to the USPS only when the RS signs the OWCP-3 and places an "X" in the "Placement — Previous Employer" box. A copy of the referral is sent to the designated area HR analyst for monitoring.

Injured employees under FECA are entitled to compensation at the total disability rate while in a rehabilitation program. The RC will request the CE to continue total disability benefits during the rehabilitation efforts.

An employee receiving compensation for a scheduled award can receive rehabilitation services; however, an employee who is concurrently receiving an OPM annuity with the scheduled award is not entitled to OWCP rehabilitation services (since the person would not otherwise be entitled to disability compensation).

Exhibit 11.4a
Sample Letter: Task Force Review Letter

[U.S. Postal Service Letterhead]

___[date]___
___[name]___ (employee's physician)
___[street address]___
___[city, state, ZIP Code]___

RE:_____

CLAIM #:_____

Dear Dr. ___[name]___:

Our records reflect that you are providing medical care to our above mentioned former employee for the job-related injury [he/she] sustained on ___[date]___.

Mr./Mrs. ___[name]___ has chosen to receive Workers' Compensation benefits under the Federal Employees' Compensation Act (FECA). ___[He/She]___ is not receiving retirement benefits.

Federal employees receiving benefits under FECA are required by statute to return to either their former or alternate work, when medically able. They are also to inquire of their treating physicians the earliest date they may return to work. The employer is required to demonstrate that suitable work is made available to the injured employee in accordance with medical capabilities.

In keeping with our obligation, we request that you complete the enclosed form to provide the employee's work restrictions and return it to this office as soon as possible. When completing the form, please document the physical limitations currently imposed on your patient's life activities *both on and off* the job. Please be aware that we can create alternative work that will simulate these limitations. Enclosed is a self-addressed stamped envelope.

Thank you for your cooperation to this matter.

Sincerely,

___[signature]___
___[name]___
Human Resources Analyst

Enclosures: CA-17
Postage-paid envelope

cc: Employee

Exhibit 11.4b

Sample Letter: Employee Scheduling for Pre-reemployment or Reassignment Medical Examination

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[injured employee's name]___
___[street address]___
___[city, state, ZIP Code]___

Dear ___[name]___:

This is in reference to the job-related injury you sustained on ___[date]___. As a result of this injury, you are being considered for ___[reemployment or reassignment]___ under the provisions of the Rehabilitation Program. To facilitate this effort, we have scheduled a ___[pre-reemployment or reassignment]___ medical examination for you. You are to report to:

Name of Doctor: _____

Address: _____

Phone: _____

Date: _____

Time: _____

It will be helpful if you will bring current medical documentation from your treating physician. Such documentation should include:

1. Diagnosis.
2. Dates of treatment.
3. Prognosis.
4. Results of pertinent medical studies.
5. Specific work restrictions (if any) and their duration.
6. Prescribed medication, including that which is (would be) required while working.
7. Date of anticipated return to work (either full or modified duty).
8. Medical justification for current disability (either total or partial).

During the course of this examination, it may be medically determined that additional testing is warranted. Therefore, please allow additional time for these studies. Please call the above-listed phone number to confirm your appointment with Dr. ___[name]___ at least 48 hours before the appointment date.

As indicated above, this examination is critical to the rehabilitation program effort. Failure to cooperate in this effort will be brought to the Office of Workers' Compensation Programs' (OWCP) attention for action deemed necessary.

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

cc: OWCP Claims Examiner, RS, and/or Rehabilitation Counselor
Examining Physician

[Note: Two copies of this letter are to be mailed to the employee as follows:

- Original: Regular mail
- Copy: Certified mail, return receipt requested.]

Exhibit 11.6a

Sample Letter: Request for Concurrence on a Management Refusal

SUBJECT: Request for Concurrence on Refusal to Extend a Job Offer

TO: MANAGER, SAFETY AND RISK MANAGEMENT
USPS HEADQUARTERS RM 9801
475 L'ENFANT PLAZA SW
WASHINGTON DC 20260-4232

THROUGH: ___[appropriate functional manager]___
___[designated area human resources analyst]___

This is in reference to the below cited Rehabilitation Program candidate:

Name: _____

SSN: _____ Claim No: _____

It is our recommendation that a job offer not be extended to Mr./Ms. ___[name]___ for the following reason:

- — Work restrictions are too severe. [Attach a copy of the pre-reemployment/reassignment medical examination (Form 2485), other supporting medical information within 1 year (if any), and a detailed explanation of the reasons an accommodation cannot be made.]
- — Non-job-related medical reasons. [Attach a copy of the Form 2485, other medical documentation within 1 year (if any), and a detailed explanation.]
- — Prior employment record. [Justification must be fully documented on a separate sheet.]

We request your concurrence on our recommendation in order to close this rehabilitation effort.

CONCUR:_____[signature]____ ___[district/plant]__ Manager___

___[functional]___ Manager___

CONCUR:_____[signature]_____ Area Human Resources Analyst

CONCUR:_____[signature]_____ Manager, Safety and Risk Management

Exhibit 11.6b

Loss of Wage-Earning Capacity

Formal LWEC Decisions

Federal Employees' Compensation Act (FECA) 5 U.S.C. 8115(a) provides compensation for the reduction of compensation to reflect a worker's earning capacity (see also 20 CFR 10.303).

The law provides for payment of compensation based upon loss of wage-earning capacity (LWEC) for permanent effects of an injury, i.e., the injured employee has reached maximum medical improvement but still continues to have residuals from the job-related injury. 20 CFR 10.303 states that an injured employee who is unable to return to the position held at the time of injury, or to earn equivalent wages, but who is not totally disabled for all gainful employment is entitled to compensation computed on LWEC (see FECA PM 2-813).

The Office of Workers' Compensation Programs (OWCP) claims examiner determines the employee's LWEC entitlement. This compensation is paid on the basis of the difference between the employee's capacity to earn wages and the current wages of the job held at time of injury. The "Shadrick" formula is used by OWCP to determine an injured employee's wage-earning capacity (see FECA PM 2-900).

As mentioned elsewhere, the USPS should request OWCP to consider issuing an LWEC decision in certain cases. It is important, however, that the ICCO ensure that such requests are appropriate. The fact that an employee may be eligible for LWEC based on a selected (or constructed) position in no way negates management's obligation to make a good faith job offer to an injured employee. Every effort must be made to identify suitable assignments and, when necessary, management refusal actions must be in compliance with procedures outlined in 11.6, Initiating Management Refusal Action.

LWEC is based on the following criteria:

— *Failure to cooperate with the early stages of the rehabilitation process.* CFR 10.124(f) provides that if an injured employee refuses to participate in rehabilitation after being directed to do so, OWCP may assume, in the absence of evidence to the contrary, that rehabilitation would have resulted in reemployment with no loss of earnings, and compensation may be adjusted to $0. However, there is no reduction to $0 if a training or job placement program is identified before the employee's refusal to cooperate. In these cases, the LWEC, even with failure to cooperate, is based on the earnings of jobs identified, not reduced to $0.

— *Actual earnings.* When an injured employee returns to alternative employment with an actual wage loss, OWCP claims examiner must determine whether the earnings in the alternative employment fairly and reasonably represent the employee's wage-earning capacity. If the earnings do fairly and reasonably represent the injured employee's wage-earning capacity, the claims examiner should prepare a formal LWEC decision.

Since it is USPS policy to make injured employees whole (no loss of earnings) upon reemployment or reassignment under the rehabilitation program, the employee's compensation should be adjusted to $0 unless the employee is not capable of working his or her normal schedule (e.g., less than 8 hours per day).

— *Selected position.* In determining the type of work a permanent partially disabled employee can perform, an OWCP claims examiner selects a specific job, taking into consideration several determination factors. These include:

  – Nature and degree of injury-related disability (and any other disability that preceded the injury).
  – Work limitation resulting from injury-related and preceding disabilities. *Note*: OWCP only takes into account disability conditions that pre-existed the injury. Disabling conditions which develop subsequent to the injury are *not* taken into account.
  – Usual or former employment.
  – Age and education of the employee.
  – Qualifications for other employment, i.e., experience.
  – Availability of suitable employment in the employee's geographical area.
  – Any other factors which may affect the employee's earning capacity.

— *Estimated earning capacity (as a last resort).* When *extensive* rehabilitation efforts do not succeed, the injured employee's wage-earning capacity is determined on the basis of a minimum of two positions deemed suitable but not actually held. In making this determination, the test is whether the injured employee's wage-earning capacity based on the selected jobs appears reasonable when considering the following factors specified in 5 U.S.C. 8115:

  – The nature of the injury.
  – The degree of physical impairment (including impairments resulting from both injury-related and preexisting conditions — any conditions arising after the compensable injury should not be considered).
  – The usual employment.
  – The injured employee's age.
  – Qualifications for other employment (including education and previous employment and training as well as work limitations imposed by the injury-related and preexisting impairments).
  – The availability of suitable employment. This is usually evaluated with respect to the area where the injured employee resides at the time of determination rather than the area of residence at the time of injury. However, when the employee voluntarily moves to an isolated locality with few job opportunities, the question of availability should be applied to the area of residence at the time of the injury. If the employee is required to move because of health conditions caused by the injury or that

predated it, availability must be considered with respect to the new area of residence.

– Other factors or circumstances. These may include the employee's aptitude for acquiring new skills, general appearance, personality factors, ability to adjust to the handicap, the industrial realities in the area where the employee is to be rated, other skills possessed by the employee, mental alertness, and the need for a license.

Modification of Formal LWEC Decisions

Once an LWEC decision has been issued, basic criteria must be met before any further change in compensation can be made. The criteria used by OWCP for modifying a formal LWEC are explained in FECA PM 2-813. These criteria are:

— The original rating was in error.

— The claimant's medical condition has changed.

— The claimant has been vocationally rehabilitated.

— A wage increase of 25 percent or greater has occurred.

Exhibit 11.7a

Sample Letter: Request for Identification of Rehabilitation Position

With Variants for Specific Addresses

SUBJECT: Potential rehabilitation program Participant —
___[name of injured employee]___

TO: ___[appropriate functional manager
or
management team members]___

This is in reference to ___[name of injured employee]___, who was injured on ___[date of injury]___, when ___[give brief description of how injury happened]___. .

As a result of this job-related injury, Mr./Ms. ___[name]___ is permanently partially disabled and is being considered for placement under the rehabilitation program. Mr./Ms. ___[name]___'s work restrictions are as follows:

___[List medically defined work restrictions]___

At the time of injury, Mr./Ms.___[name]___ was a ___[position title]___, assigned to ___[name of work site]___, and worked on tour ___[number]___. Mr./Ms. ___[name]___'s last day in a work status was ___[date]___.

Your assistance is requested in identifying an assignment consistent with Mr./Ms. ___[name]___'s medical limitations. When identifying such an assignment, please bear in mind management's responsibility to minimize any adverse effect on the employee. Whenever possible, placement should be made in the same craft, facility, and tour in which the employee was assigned at the time of the injury/disability. When this is not possible, further consideration should be given in the order of priority cited on attachment.

[The next paragraph will vary depending on the addressees.]

[When addressed to a specific functional manager:]
If you have any questions and/or require assistance in identifying a suitable assignment, please contact ___[name and phone number of injury compensation control office person handling the case]___. It would be appreciated if your response was received by ___[date response needed]___ .

[When addressed to management team members:]
This rehabilitation program effort will be discussed at the next management team meeting scheduled for ___[date and time of meeting]___. The meeting will be held in ___[location]___.

Thank you for your assistance in this matter.

___[signature]___
Senior Injury Compensation Specialist

Attachment: Rehabilitation Assignment Priority [see Exhibit 11.7b].

Exhibit 11.7b
Rehabilitation Assignment Priority

Whenever possible, assign qualified employees to rehabilitation job assignments duty in *their regular craft, during regular tour of duty, and in their regular work facility.*

Prioritize the rehabilitation job assignment in the following manner:

— To the extent that there is adequate work available within the employee's work limitation tolerances, within the employee's craft, in the work facility to which the employee is regularly assigned, and during the hours when the employee regularly works, that work constitutes the rehabilitation job assignment to which the employee is assigned.

— If adequate duties are not available within the employee's work limitation tolerances in the craft and work facility to which the employee is regularly assigned within the employee's regular hours of duty, other work may be assigned within that facility.

— If adequate work is not available at the facility within the employee's regular hours of duty, work outside the employee's regular schedule may be assigned as rehabilitation. However, all reasonable efforts must be made to assign the employee to a rehabilitation job assignment within the employee's craft and to keep the hours of the rehabilitation job assignment as close as possible to the employee's regular schedule.

— An employee may be assigned rehabilitation outside of the work facility to which the employee is normally assigned only if there is not adequate work available within the employee's work limitation tolerances at the employee's facility. In such instances, every effort must be made to assign the employee to work within the employee's craft within the employee's regular schedule and as near as possible to the regular work facility to which the employee is normally assigned.

If it is necessary to change any of the elements to meet the employee's physical limitations or to provide the employee with suitable work, the elements must be changed in this specific order:

Priority of Choice	Regular Craft	Regular Tour	Regular Facility
1st	Within	Within	Within
2nd	Outside	Within	Within
3rd	Within	Outside	Within
4th	Outside	Outside	Within
5th	Within	Within	Outside
6th	Outside	Within	Outside
7th	Within	Outside	Outside
8th	Outside	Outside	Outside

Exhibit 11.7c

Contractual Obligations for Rehabilitation Positions

Reemployment or reassignment must be in compliance with applicable collective bargaining agreements. Individuals so reemployed or reassigned must receive all appropriate rights and protection under the newly applicable collective bargaining agreement.

When preparing to make a job offer, ensure that contractual obligations have been addressed.

Employee Status

These obligations include the following:

— If a current employee is accommodated in his or her current position, his or her status will remain the same.

— If a current employee is reassigned or a former employee reemployed, he or she may work as an unassigned regular or as a part-time flexible employee.

— If a partially recovered current or former employee is reassigned or reemployed to a different craft to provide appropriate work, he or she will not normally be assigned to a residual vacancy when it impairs the seniority rights of a part-time flexible employee.

Compliance under the Snow Arbitration Decision Case No. HOC-3N-C-418 must be met, i.e., assignments of partially recovered employees across craft lines cannot be made to the detriment of part-time flexible employees. This means that if there are part-time flexible employees in the same craft where the recovered employee is to be assigned, he or she normally must be made the junior part-time flexible employee.

However, the USPS guarantees that these employees do not lose pay as a result of the assignment. Because they are entitled to at least the number of workhours earned at the time of injury, it would benefit the USPS to schedule the employee the same number of hours as his or her former assignment and receive the current rate of pay in the part-time flexible pay schedule that was earned at the time of injury.

Note that the part-time flexible schedule pays a higher hourly rate that compensates for not getting holiday pay. The end result is that the part-time flexible is paid an hourly rate higher than the full-time regular position but the annual pay remains the same.

Minimum qualification requirements, including written examinations, may be waived in individual cases for former or current employees injured on duty and considered for reemployment or reassignment. When there is evidence, including that submitted by the medical officer, that the employee can be expected to perform satisfactorily in the position within 90 days after assignment, one of the following may grant a waiver:

- For Headquarters and Headquarters field unit positions, the vice president of Human Resources.
- For area positions, an area HR manager.
- For other field positions, a district HR manager.

Seniority

Former employees who are reemployed into bargaining unit positions or current career employees who are reassigned into such positions are credited with seniority in accordance with the collective bargaining agreement covering the position to which they are assigned.

Exhibit 11.8a

Sample Modified Job Description

Rehabilitation Program Job Description for Patty P. Peachtree

TITLE: Clerk, Distribution (Modified), Part-Time Flexible
LOCATION: Tree Grove Station
TOUR: Tour 2 (07:30 a.m. – 04:00 p.m.)

Duties to Be Performed

Casing mail at a modified distribution case (sorts mail into pigeonholes). Note: Employee will not be required to lift trays of mail. Trays will be placed on ledge of case for the employee.

Physical Activity Required to Perform Duties

Intermittent sitting in a chair with a back support for no more than 2 hours at a time, reaching no higher than shoulder level, lifting no more than 5 pounds.

Other duties that may be assigned include:

- Answering phones.
- Rewrapping damaged parcels.

Other duties, when assigned, will require activity not to exceed lifting of more than 10 pounds, sitting for more than 2 hours in a chair with a back support, reaching above shoulder level, or walking for more than 1 hour. Employee will not be required to bend, squat, or kneel.

Environmental Factors

All work performed inside in a heated or air-conditioned work area.

Other Factors

[Describe any other factors that may be pertinent to the specific case, e.g., exposure to chemicals, etc.]

Exhibit 11.8b

Request for Medical Review of Proposed Job Description

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___

Dear Doctor ___[name of reviewing physician]___:

This is in reference to Mr./Ms. ___[name]___, who was injured in the course of [his/her] employment with the U.S. Postal Service on ___[date of injury]___. As a result of this injury, Mr./Ms. ___[name]___ is considered permanently partially disabled.

In view of the above, Mr./Ms. ___[name]___ is being considered for permanent placement in a modified assignment that will accommodate his or her limitations. A proposed job description has been prepared in accordance with the work restriction evaluation report, which was completed by ___["you"/name of physician who completed the report]___, on ___[date report was completed]___. Copies of both the proposed job description and the work restriction evaluation report are attached.

In order to facilitate Mr./Ms. ___[name]___'s placement, your assistance is requested. It would be most appreciated if you would review the attached documents and determine if the proposed job description is in compliance with Mr./Ms. ___[name]___'s work restrictions. For your convenience, you may respond by completing the lower portion of this letter. A self-addressed return envelope is also enclosed. A response by ___[date response is needed]___ would be extremely helpful.

Thank you for your attention to this matter.

Sincerely,

___[signature]__
___[name]___
Senior Injury Compensation Specialist

Attachments: Proposed Job Description
Work Restriction Evaluation

I have reviewed the proposed job description and, in my opinion:

__ It is in compliance with Mr./Ms.___[name]___'s restrictions
__ It is not in compliance with Mr./Ms.___[name]___'s restrictions. The job description should be revised as follows:____[details of proposed revision]___.

_____

(Signature of Reviewing Physician) (Date)

cc: Employee

Exhibit 11.8c

Sample Letter: Rehabilitation Program Job Offer

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Reemployment/Reassignment Offer
To: ___[injured employee's name]
___[street address]___
___[city, state, ZIP Code]___

RE: OWCP Claim No.

Certified No._____

Based on the positive results of your pre-reemployment/reassignment physical examination conducted on ___[date]___, we are offering you the following position:

Modified Distribution			
Clerk — Full-Time	5	0 $31,766 (incl. cost of living allowances)	
Title	Grade	Step	Salary
Tree Grove, GA	2	0750 – 1600	Sun/Mon
Post Office	Tour	Time	Days Off

The duties of the proposed position are outlined on the attached job description and are in strict compliance with your medically defined work limitations. Your work limitations are as follows:

[List work restrictions.]

Please review the attached job description, indicate your decision by signing in the appropriate space below, and return this letter within 10 days following receipt. A self-addressed return envelope is enclosed for your convenience.

If you believe that this position is not a proper restoration, you may appeal to the Merit Systems Protection Board (MSPB) as outlined in 5 CFR 353. Such an appeal must be submitted to MSPB within 30 days after the date of offer, or 30 days after the date of reemployment/reassignment, whichever is later.

If you refuse to accept this reemployment/reassignment offer, we will so advise the Office of Workers' Compensation Programs (OWCP) for whatever action they deem necessary. Further entitlement to compensation benefits may be affected.

Should you have any questions before making a decision, you may contact ___[name of ICCO person handling case]___ at ___[telephone number]___.

___[signature]___
___[name]___
Manager, Human Resources

Attachment: Sample Modified Job Description [See Exhibit 11.8a.]

I ACCEPT YOUR POSITION OFFER	I REFUSE YOUR POSITION OFFER FOR THE REASONS CITED BELOW
_____	_____
Signature	Signature
_____	_____
Date	Date

Comments: _____

_____

_____

_____

_____

cc: Rehabilitation Counselor
OWCP Claims Examiner
Area Human Resources Analyst

Exhibit 11.9a

Sample Letter: Employee Scheduling for Pre-reemployment or Reassignment Interview

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[injured employee's name]___
___[street address]___
___[city and state]___

OWCP Claim No._____

Certified No._____

Dear Mr. or Ms. ___[name]___:

This is in reference to your job-related injury which you sustained on ___[date of injury]___ . After a careful review of the most recent medical information, we have determined that you may be eligible for placement in a permanent assignment under the Rehabilitation Program.

To discuss the possibility of your ___[reemployment/reassignment]___ , an appointment for an interview as been scheduled for you at the date, time, and location cited below. A job description has been prepared in strict compliance with your medically defined work limitations. The job description, along with a job offer, will be discussed during the interview.

Date: _____

Time: _____

Location: _____

_____

I am looking forward to explaining the Rehabilitation Program to you and discussing the possibility of your ___[reemployment/reassignment]___ within the U.S. Postal Service. If you are unable to keep this appointment, please contact me at ___[ICCO phone number]___. Please be aware that failure to appear for this appointment and/or contact this office may adversely affect your entitlement to future Office of Workers' Compensation Programs (OWCP) compensation benefits.

Sincerely,

___[signature]___
___[name]___
___[ICCO person handling the case]___

cc: ___[Interview attendees]___

Exhibit 11.9b

Pre-reemployment or Reassignment Employee Interview Checklist

1. Explain the specific duties required of the position that is being offered under the Rehabilitation Program.
2. Explain the physical requirements demanded of the position. (If applicable, advise employee that the job description was reviewed by a physician (name the physician) who determined that the proposed duties were in compliance with the employee's work restrictions.)
3. Inform employee of the location of the work facility and work schedule being assigned.
4. Explain fully all restoration rights, responsibilities, and benefits upon reemployment:
   - *Employee status seniority.* These are based upon provision of the applicable U.S. Postal Service collective bargaining agreements covering the position to which the employee is being assigned.
   - *Probation period.* Reemployed individuals who have completed their probationary periods, or individuals who would have completed their probationary periods but for their compensable injuries, are not required to serve a new probationary period.
   - *Leave credit.* Total time on Office of Workers' Compensation (OWCP) rolls will be creditable for computing leave rate accrual.
   - *Salary determination.* This is based upon the position to which the individual is reemployed/reassigned.
   - *Retirement:*
     - A separated (nonretired) employee who returns to work, either part time or full time, receives full credit for time spent on FECA rolls, but his or her family may be left without survivor's benefits in event of death.
     - An employee who has applied for and been approved for retirement, even if he or she receives Federal Employees' Compensation Act (FECA) benefits and never receives disability annuity, will not always receive credit for time spent on FECA rolls when returning to work. In this case, future retirement benefits are determined in accordance with 5 U.S.C. 8344(a).
   - *Bid rights*. Reemployed/reassigned individuals may bid on other positions provided they meet the physical requirements of the job. If a Rehabilitation Program employee is a successful bidder on another position, the employee will no longer be a Rehabilitation Program participant unless the employee's work restrictions continue.

— *Medical Treatment.* The individual is entitled to continued medical treatment, if needed, as a result of the injury.

— *Disability Retirement.* The individual is entitled to apply for these benefits if, after returning to work, he or she is medically determined to be permanently disabled from performing any type of work.

5. Inform the employee of the time required for receipt of acceptance or declination of job offer before follow-up action is initiated (usually 2 weeks).
6. Inform the employee that refusal of a valid job offer may result in termination or reduction of OWCP benefits.
7. Document the date the pre-reemployment/reassignment interview was held and other pertinent information relating to the interview.

Exhibit 11.9c

Restoration Rights and Benefits

The U.S. Postal Service has legal responsibilities to employees with job-related disabilities under 5 U.S.C. 8151 and the Office of Personnel Management (OPM) regulations.

Upon full recovery, former and current injured employees will be returned to their regular or former (or equivalent) positions as stated in Chapter 4, Claims Management. All rights and benefits that the employee would have had or have acquired in the regular or former position had there been no injury or disability are restored.

Upon partial recovery, former employees being reemployed and current employees being reassigned under the provisions of the Rehabilitation Program are entitled to the following rights and benefits:

— *Probationary period*: Individuals who have completed their probationary periods, or would have completed their probationary periods but for their compensable injuries, are not required to serve a new probationary period.

— *Leave credit*: For purposes of computing leave rate accrual, former employees who were eligible to accrue leave are credited, upon reemployment, with the total time compensation was received from Office of Workers' Compensation Programs (OWCP).

— *Retirement benefits*: See Exhibit 11.9d, Retirement Considerations.

— *Salary determination*: The following salary restoration criteria must be met for both reemployment and reassignment of former and current employees. Note: the term grade or step, as used below, means grade or salary for individuals in a nonstep salary schedule.

  – *Reemployment or reassignment to the grade or step at time of disability.* Individuals receive the current salary for that grade and the step that the individual would have acquired had there been no injury or disability.

  – *Reemployment or reassignment to a higher grade.* Individuals placed in a position with a grade higher than that of the position held at time of disability are placed at the current salary for the grade or step that the individual would have acquired had there been no injury or disability.

  – *Reemployment or reassignment to a lower grade.*

    - *The salary below maximum of lower grade.* The individual will be placed in any higher step in the lower grade less than one full step above the current salary for the grade or step that the individual would have acquired had there been no injury or disability.

- *Salary above maximum of lower grade.* In those cases where the current salary for the grade or step that the individual would have acquired had there been no injury or disability exceeds the maximum salary of the lower grade position, the employee is afforded a saved rate at the higher grade and step salary. These saved-rate provisions apply for an indefinite period and are subject to the rules of the salary schedule assigned for the following employees:
- Former career employees who are being reemployed under the provisions of the rehabilitation program.
- Current career employees who accept a job offer and are permanently reassigned because of a job-related injury.
- Limited duty career employees who are permanently reassigned because of a job-related injury.

— *Reemployment or reassignment to a position in a different salary schedule.* When an individual is reemployed or reassigned to a position in a salary schedule different from the schedule under which the employee was paid at the time of injury or disability, the individual is treated under the following rules, applicable to the new salary schedule:

– The individual is reemployed or reassigned at the grade appropriate for the position to which he or she was reemployed or reassigned.

– The individual is placed in any higher step in the new grade less than one full step above the current salary for the grade or step the individual would have acquired had there been no injury or disability.

– If reemployment or reassignment is to a nonstep schedule, the individual is placed at a salary plus any salary increases the individual would have acquired had there been no injury or disability. Merit salary increases (546.142 (3) (b)) are based on the most recent performance rating before the injury or disability.

– If the current salary for the grade the individual would have acquired had there been no injury or disability exceeds the maximum salary of the new grade, the individual is given a saved rate. These saved-rate provisions apply for an indefinite period and are subject to the rules of the salary schedule to which assigned for the following employees:

- Former career employees.
- Limited duty career employees.
- Current career employees who have accepted a job offer and are reassigned to a lower grade because of a job-related injury.

– *Former position under a different salary schedule.* If the position held at the time of injury or disability is no longer under the same salary schedule, the current salary for the former grade or step is determined for Headquarters and Headquarters field units by the vice president of Human Resources (HR); for area positions, the area HR managers; and for field positions, the district HR manager within the district boundaries.

— *Step increases*:
  – Upon reemployment under the provisions of the Rehabilitation Program, former employees are assigned a new waiting period for step or merit increases.
  – Upon return to work or reassignment, current employees who were in a LWOP-IOD status receive credit for the period of absence as if duty with the USPS had been continuous for step increase purposes. The date assigned is based on the effective date for the most recent step, merit, or equivalent increase the individual would have acquired had there been no injury or disability.
  – Upon reassignment of limited duty employees, standard step increase procedures apply.

Exhibit 11.9d

Retirement Considerations

Employee Notification

Ensure that the potential Rehabilitation Program participant is advised during the pre-reemployment interview of the effect the reemployment will have on future retirement benefits.

Disability Annuitant Status Ceases

The reemployment status of a disability annuitant is determined by the continuing nature of his or her disability annuity and restoration of that individual's wage-earning capacity. The disability annuitant status will cease if the individual meets the following conditions:

— Reemployed to full-time employment.

— Deemed recovered, restored to earning capacity, or found administratively recovered by Office of Personnel Management (OPM).

Individuals whose disability annuitant status ceases will receive credit for time spent on Office of Workers' Compensation Programs (OWCP) rolls during periods of separation, and they will be covered by the same retirement system they were entitled to before the separation. Their future retirement benefits will be based on their reemployment.

Disability Annuitant Status Remains

A disability annuitant status will remain if the individual meets the following conditions:

— Reemployed to part-time employment (working less than full time).

— Receiving compensation from OWCP during reemployment.

Example: A former full-time distribution clerk with disability annuitant status partially recovers from a compensable job-related injury and is reemployed under the Rehabilitation Program. However, medical restrictions limit work to 20 hours per week. In this case, wage-earning capacity has not been restored because the employee is unable to earn wages equivalent to wages of the position held at the time of injury or disability.

These individuals will not receive credit for the period of separation during which the annuitant received OWCP benefits. For reemployment purposes, OPM considers these former employees to be "reemployed annuitants." Although they will be placed under the same retirement system, they were covered by before their separation, retirement deductions for Civil Service Retirement System (CSRS) reemployed annuitants are optional. CSRS annuitants must file an election to have CSRS deductions withheld from their pay during reemployment. This option does not apply to Federal Employees' Retirement System (FERS) disability annuitants. FERS reemployed annuitants will have retirement

contributions withheld during their period of reemployment. Personnel offices must refer to subchapter 100 of the *OPM CSRS and FERS Handbook for Personnel and Payroll Offices* for guidance when hiring reemployed annuitants.

Reinstatement of Eligibility

Reemployed annuitants continue to maintain their OPM annuitant status. Consequently, upon separation from reemployment, they are eligible for:

— Their disability annuity, plus any cost-of-living allowances granted retirees during the period they were not receiving an annuity.

— If they complete the equivalent of at least 1 year of full-time employment, a supplemental annuity based on their period of reemployment.

— If they complete the equivalent of at least 5 years of full-time employment, their annuities redetermined to include all periods of service, including the time spent on OWCP rolls during the period of separation.

Former annuitants reemployed under the procedures in this chapter may be entitled to the restoration of disability retirement status if they are later found unable to perform successfully in the new position because of the original compensable injury or disability and are again separated.

Job Offer Made But Individual Fails to Cooperate

A former employee who has an approved OWCP disability claim and an approved disability retirement on file with OPM has the right to elect benefits from either OWCP or OPM. Once the employee has elected OWCP benefits, any subsequent election should be initiated by either OWCP or the injured employee.

With the above in mind, the senior injury compensation (IC) specialist must ensure that any communication regarding the job offer or the employee's failure to cooperate in the rehabilitation effort originating from the injury compensation control office (ICCO) does not include any reference to an election of OPM benefits. OWCP will not consider the employee to have made an informed election of benefits unless the employee was advised by OWCP that the job is considered to be suitable, and notified of the consequences of a refusal without reasonable cause.

If the employee decides not to accept the job offer or fails to cooperate in the rehabilitation effort, an election of OPM benefits will be offered when appropriate by OWCP, and the employee may voluntarily elect to receive OPM disability annuity.

OPM Notification

Upon reemployment of a disability annuitant (or in advance, if possible), the senior IC specialist must ensure that the Office of Personnel Management (OPM) is notified. OPM must be notified in all cases where the reemployed individual

was previously approved for an annuity, even in cases where it was waived in lieu of OWCP benefits. Failure to notify OPM may adversely affect the employee's future retirement benefits.

Separated Employee Status

— Former employees who were separated from the USPS but *who did not apply for a disability annuity* will receive retirement credit for all time spent on OWCP rolls, including periods of separation.

— Former employees who were separated from the USPS but *who did apply for disability annuity will not* receive retirement credit for any time spent on the OWCP roles, including periods of separation.

Current Employee Status

Current employees (never separated from the U.S. Postal Service) will receive retirement credit for all time spent on OWCP rolls while in an LWOP-IOD status.

Additional Guidance

See Exhibit 11.9e, Questions and Answers on Retirement Credit for Time Spent in Receipt of OWCP Benefits.

Exhibit 11.9e

Questions and Answers on Retirement Credit for Time Spent in Receipt of Office of Workers' Compensation Programs Benefits

General Service Credit

Q. *Does a retiring employee receive full credit in his or her retirement computation for periods of leave without pay (LWOP) and separation during which he or she receives Office of Workers' Compensation (OWCP) benefits?*

A. Yes. As long as the period(s) involved occurred before the separation on which eligibility to the annuity is based, this service is available as service credit for purposes of eligibility, average salary, and length of service.

Q. *Is there any purpose for which a period of separation during which the employee received OWCP benefits cannot be credited?*

A. Yes. A period of separation cannot be credited in meeting the 1-year-out-of-2 provision of Civil Service Retirement System (CSRS), irrespective of the separated employee's entitlement to OWCP benefits.

Q. *What is the 1-year-out-of-2 provision?*

A. Under the 1-year-out-of-2 provision, a CSRS employee must complete 1 year of creditable service subject to retirement deductions in the 2 years immediately preceding his or her separation before being eligible for a nondisability retirement based on that separation. Federal Employees' Retirement System (FERS) does not have the same requirement.

Employees and Annuitants

Q. *What is the difference between a separated employee and an annuitant?*

A. A separated employee is a former federal employee who was covered by either CSRS or FERS. An annuitant is a separated employee who has applied for and received either a CSRS or FERS annuity on the basis of his or her separation.

Q. *Is an annuitant who elects to receive OWCP benefits for loss of wage-earning capacity (LWEC) in lieu of annuity still considered an annuitant?*

A. Yes. This is because he or she may, at any time, reverse the election and choose to receive an annuity in lieu of OWCP benefits.

Q. *How can an annuitant receive retirement credit for periods of separation after retirement during which he or she receives employee's compensation in lieu of civil service annuity?*

A. An annuitant can credit periods of separation during which he or she receives OWCP benefits in lieu of annuity by becoming reemployed and earning new title to annuity based on a separation that occurs after the period of receipt of OWCP benefits.

Reemployed Annuitants

Q. *How does an annuitant earn a new title to annuity?*

A. A new title to annuity can only be earned through reemployment. When the right to annuity ceases on or during reemployment, a new right to an immediate or deferred annuity will be determined at the time of the employee's next separation. CSRS employees must meet the 1-year-out-of-2 provision (see question 3) in order to establish a new title to a nondisability annuity. When the right to annuity continues during reemployment, a new title to annuity is earned only when the reemployed annuitant completes 5 years of actual, continuous, full-time service, or the part-time equivalent, and earns a right to a redetermined annuity.

Q. *What kinds of annuities terminate on or during reemployment?*

A. Under CSRS, a discontinued service annuity terminates when the employee is reemployed in a position that would be covered by CSRS. Other CSRS annuities terminate when the annuitant is reemployed under special circumstances, such as becoming a member of Congress or a Presidential appointee. All other annuities, and the right to receive annuity, are not directly affected by reemployment. However, special rules apply to disability annuities that terminate during reemployment.

Q. *What are the special rules that apply to disability annuities that terminate during reemployment?*

A. When a CSRS or FERS disability annuitant is found recovered or restored to earning capacity by Office of Personnel Management (OPM), the normal termination date can be affected by reemployment. A disability annuity usually terminates 1 year after the date of a finding of recovery, or 6 months after the end of the calendar year for which the disability annuitant was found restored to earning capacity. When a disability annuitant who has been found recovered or restored to earning capacity is reemployed before the ordinary termination date of the annuity, the annuity terminates on the later of (a) the date of reemployment or (b) the date of OPM's finding.

Q. *On what basis can a disability annuitant be found recovered?*

A. OPM will find a disability annuitant recovered from his or her disability in either of these cases:

   a. Medical evidence shows that the medical condition that initially caused the disability has ameliorated to the point that the annuitant is no longer disabled for the position from which he or she retired.

   b. The annuitant is permanently reemployed, under CSRS or FERS, in a position of the same grade or pay level as the position from which he or she retired.

Q. *What circumstances will prevent OPM from making a recovery finding on the basis of reemployment?*

A. If the disability annuitant is age 60 or over, he or she may only be found recovered at his or her own request. Also, if the reemployed disability annuitant continues to receive OWCP benefits on the basis of loss of wage-earning capacity (LWEC) (working less than full time), a recovery finding on the basis of reemployment is inappropriate.

Q. *May a reemployed disability annuitant request OPM to make a finding of recovery from disability? What effect does the request have?*

A. Yes. A reemployed disability annuitant may request to be found recovered from his or her disability. A disability annuitant age 60 or over may only be found recovered at his or her request. However, an annuitant's request cannot constitute the sole basis for a recovery finding. There must also be evidence of medical recovery or equivalent employment. To receive prompt attention, a request for a recovery finding should be accompanied by such documentation.

Q. *On what basis may a disability annuitant be found restored to earning capacity?*

A. A disability annuitant is deemed restored to earning capacity when, at the end of any calendar year in which the annuitant is under age 60, the annuitant's earnings equal or exceed 80 percent of the current pay of the position from which the annuitant retired.

Q. *Are OWCP benefits counted as part of a disability annuitant's earnings either for restoration to earning capacity purposes or as part of his or her salary for average salary purposes?*

A. No.

Q. *How is average salary computed, especially when the employee is working a part-time schedule?*

A. Average salary is computed on the rate of basic pay (excluding cost of living allowances (COLA)) of the position, not on how much the employee is actually paid. For part-time service before April 7, l986, the full-time annual rate of the position is prorated by the employee's part-time work schedule. Part-time service on or after that date is credited at the full-time salary rate, but the amount of service is prorated.

Q. *What CSRS or FERS benefits are payable if the reemployed annuitant (whose annuity terminated on or during reemployment) separates without new title or either immediate or deferred annuity?*

A. If a nondisability annuity terminated on or during reemployment, it may be reinstated as of the date of separation.

If a disability annuity terminated on or during reemployment, and the employee is (a) still, or once again, disabled by the same medical condition and (b) under age 62, the disability annuity may be reinstated.

If a disability annuity terminates on or during reemployment, but the employee does not meet the above, he or she may be entitled to discontinued service annuity based on the termination of the disability annuity. To meet this requirement, he or she will need to have 25 years of service when he or she initially retires, or 20 years of service, and be age 50 or over when the disability annuity terminates. If none of the above circumstances applies to the employee, he or she will be entitled to a deferred annuity based on the previous separation.

Q. *What benefits will be payable to a reemployed annuitant whose annuity does not terminate during reemployment if he or she is not entitled to a redetermined annuity?*

A. If the annuitant completes at least 1 year of actual, continuous full-time reemployment service, or its part-time equivalent, he or she will be entitled to a supplemental annuity. A supplemental annuity is in addition to the regular annuity.

Q. *Can periods of separation during which the annuitant receives OWCP benefits be included in the computation of the supplemental annuity?*

A. No. Only actual reemployment service may be used in the computation of a supplemental annuity.

Exhibit 11.11a
Sample Letter: Employee Report to Duty

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[employee's name]___
___[street address]___
___[city, state, ZIP Code]___

RE: OWCP Claim No._____

Certified No._____

Dear Mr./Ms.___[name]___:

This is in reference to your acceptance of the job offer we extended on ___[date of job offer]___ under the provisions of the Rehabilitation Program.

We are pleased to advise you that your new assignment becomes effective on ___[effective date]___. Please report to the person and location as indicated below:

Name: _____

Title:_____

Location: _____

_____

Time:_____

If you have any questions or require clarification regarding this assignment, please contact ___[name of ICCO person]___ at ___[telephone number]___.

Congratulations on your ___[reemployment/reassignment]___!

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

cc: OWCP Claims Examiner ___[and/or]___ Rehabilitation Specialist
Manager, ___[work site]___
Personnel Services Office

Exhibit 11.11b

Sample Form 50 Actions

01	EFFECTIVE DATE	NOTIFICATION OF PERSONNEL ACTION	02	SOCIAL SECURITY NUMBER
	12-27-95			111-00-1225

EMPLOYEE INFORMATION

03	EMPLOYEE NAME-LAST	DOE	39	FLSA STATUS	N-NON-EXEMPT
04	EMPLOYEE NAME-FIRST	JANE	40	PAY LOCATION	001
05	EMPLOYEE NAME-MIDDLE		41	RURAL CARRIER-POUTE	
06	MAILING ADDRESS STREET/BOX/APT	124 FIRST STREET	42	RURAL CARR-L-RTE ID	
			43	RURAL CARR-PAY TYPE	
07	MAILING ADDRESS-CITY	BALTIMORE	44	RURAL CARR-TSI-WEEKLY	
08	MAILING ADDRESS-STATE	MD	45	RURAL CARR-FLSA	
09	MAILING ADDRESS-ZIP+4	21231-1234	46	RURAL CARR-COMBIT	
10	DATE OF BIRTH	02-26-55	47	RURAL CARR-EMA	
11	VETERANS PREFERENCE	5-5 POINTS	48	RURAL CARR-HOURS	
12	SEX		49	RURAL CARR MILES	
13	MINORITY		50	JOB SEQUENCE	1
14	DISABILITY		51	OCCUPATION CODE	2340 DIEK
15	LEAVE COMP DATE	02-05-79	52	POSITION TITLE	GEN CLK
16	ENTER ON DUTY DATE	02-05-79	53	LABOR DIST CODE	6900
17	RETIREMENT COMP DATE	02-05-79	54	DESIGNATION/ACTIVITY	1170
18	SERV ANNIVERSARY PPYR	06-79	55	POSITION TYPE	1-FULL TIME
19	TSP ELIGIBILITY	2-ELIGIBLE W/O DEDUCT	56	LIMIT HOURS	
20	TSP SERVICE COMP DATE		57	ALLOWANCE CODE	
21	PRIOR CSRS SERVICE		58	EMPLOYMENT TYPE	
22	FROZEN CSRS TIME		**SALARY INFORMATION**		
23	LEAVE DATA-CATEGORY	8-HOURS/PP	59	PAY RATE CODE	A-ANNUAL RATE
24	LEAVE DATA-END PPYR	06-94	60	RATE SCHEDULE CODE	01-PS
25	LEAVE DATA-TYPE	1-ADVANCED AT BEGINNING	61	GRADE-STEP	05/0
26	CREDIT MILITARY SERV		62	SALARY	16,031
27	RETIRED MILITARY		63	COLA	
28	RETIREMENT PLAN	4-CSRS	64	COLA ROLL-IN IND	
29	EMPLOYEE STATUS	00-PRIOR COMP CURRT EMP	65	NEXT STEP PPYR	
30	LIFE INSURANCE	C-BASIC COVERAGE ONLY	66	MERIT AWARD DATE	
31	SPECIAL BENEFITS		67	MERIT CYCLE YEAR	
POSITION INFORMATION			68	SPECIAL SALARY CODE	
32	EMPLOY OFFICE-ID NO	23-0378	69	PROTECTED RSC	
33	EMPLOY OFFICE-NAME	BALTIMORE/AO'S	70	PROTECTED GRADE/STEP	
34	EMPLOY OFFICE-ADDRESS	BALTIMORE MD 21273-9498	71	EXPIRATION PPYR	
			72	PROTECTED PC HOURS	
35	DUTY STATION-ID NO	23-0378	73	PROTECTED PC MILES	
36	DUTY STATION-NAME	BALTIMORE/AO'S	74	PC GUARANTEED SALARY	
37	APPT EXPIRATION DATE		75	ANNUITY AMOUNT	
38	PROBATION EXPIR DATE		76	WFD CYCLE CODE	0

NATURE OF PERSONNEL ACTION

77	NATURE OF ACTION CODE	721	78	AUTHORITY				79 USC Sect 1081			
79	DESCRIPTION	REASSIGNMENT	80	CODE		A]	CODE	82	CODE	A]	CODE
84	REMARKS										

85	AUTHORIZATION	86	PROCESSED DATE	12-28-95
	VICE PRESIDENT, AREA OPERATIONS	87	PERSONNEL OFFICE ID	
		88	OPF LOCATION	

PS Form 50, MARCH 1986 (EXCEPTION TO STANDARD FORM 50)

Exhibit 11.11b
Sample Form 50 Actions (continued)

01	EFFECTIVE DATE	NOTIFICATION OF PERSONNEL ACTION	02	SOCIAL SECURITY NUMBER
	12-31-95			111-02-1225

EMPLOYEE INFORMATION

03	EMPLOYEE NAME-LAST	SMITH	39	PAY STATUS	N-NON-EXEMPT
04	EMPLOYEE NAME-FIRST	JOHN	40	PAY LOCATION	0171
05	EMPLOYEE NAME-MIDDLE		41	RURAL CARRIER-ROUTE	
06	MAILING ADDRESS STREET/BOX/APT	124 FIRST STREET	42	RURAL CARR-L-RATE JB	
07	MAILING ADDRESS-CITY	BALTIMORE	43	RURAL CARR-PAY TYPE	
08	MAILING ADDRESS-STATE	MD	44	RURAL CARR-TPI-WEEKLY	
09	MAILING ADDRESS-ZIP+4	21238-8216	45	RURAL CARR-FLSA	
10	DATE OF BIRTH		46	RURAL CARR-COMBAT	
11	VETERANS PREFERENCE		47	RURAL CARR ETA	
12	SEX		48	RURAL CARR-HOURS	
13	MINORITY		49	RURAL CARR-MILES	
14	DISABILITY		50	JOB SEQUENCE	T
15	LEAVE COMP DATE	02-05-79	51	OCCUPATION CODE	7371-[illegible]
16	ENTER ON DUTY DATE	02-05-79	52	POSITION TITLE	DIST CLK
17	RETIREMENT COMP DATE	02-05-19	53	LABOR DIST CODE	6900
18	SERV ANNIVERSARY YR+M	04-79	54	DESIGNATION/ACTIVITY	1170
19	TSP ELIGIBILITY	E ELIGIBLE W/O DEPOSIT	55	POSITION TYPE	1-FULL TIME
20	TSP SERVICE COMP DATE	00-00-00	56	LIMIT HOURS	
21	PRIOR CSRS SERVICE		57	ALLOWANCE CODE	
22	FROZEN CSRS TIME		58	EMPLOYMENT TYPE	
23	LEAVE DATA-CATEGORY	6-HOURS/PP		**SALARY INFORMATION**	
24	LEAVE DATA-END YR+M	06-90	59	PAY RATE CODE	A-ANNUAL RATE
25	LEAVE DATA-TYPE	1-ADVANCED AT BEGINNING	60	RATE SCHEDULE CODE	P-PS
26	CREDIT MILITARY SERV		61	GRADE/STEP	05/0
27	RETIRED MILITARY		62	SALARY	30,031
28	RETIREMENT PLAN	1-CSRS	63	COLA	
29	EMPLOYEE STATUS	RD-RETIRS COMP (CURRENT EMP	64	COLA ROLL-IN IND	
30	LIFE INSURANCE	C-BASIC (COVERAGE ONLY	65	NEXT STEP YR+M	
31	SPECIAL BENEFITS		66	MERIT ANNIV DATE	
	POSITION INFORMATION		67	MERIT LUMP SUM	
32	EMPLOY OFFICE-PAY NO	21 0378	68	SPECIAL SALARY CODE	
33	EMPLOY OFFICE-NAME	BALTIMORE/AD'S	69	PROTECTED RSC	
34	EMPLOY OFFICE-ADDRESS	BALTIMORE MD 21231-9448	70	PROTECTED GRADE/STEP	
35	DUTY STATION-FIN NO	21-0378	71	EXPIRATION PAYP	
36	DUTY STATION-NAME	BALTIMORE/AD'S	72	PROTECTED RC HOURS	
37	APPT EXPIRATION DATE		73	PROTECTED RC MILES	
38	PROBATION EXPIR DATE		74	RC GUARANTEED SALARY	
			75	ANNUITY AMOUNT	
			76	WEB CIRCLE CODE	0

NATURE OF PERSONNEL ACTION

77	NATURE OF ACTION CODE	292	78	AUTHORITY				30	USC Sect 1081		
79	DESCRIPTION	RETURN TO DUTY (RTD)	80	CODE		8C	CODE	32	CODE	33	CODE
84	REMARKS										

85	AUTHORIZATION	86	PROCESSED DATE	12-28-95
	VICE PRESIDENT, AREA OPERATIONS	87	PERSONNEL OFFICE ID	
		88	OPF LOCATION	

PS Form 50, MARCH 1988 (EXCEPTION TO STANDARD FORM 50)

Exhibit 11.11b
Sample Form 50 Actions (continued)

1	EFFECTIVE DATE		NOTIFICATION OF PERSONNEL ACTION	2	SOCIAL SECURITY NUMBER
	12-23-95				111-01-1225

EMPLOYEE INFORMATION

3	EMPLOYEE NAME. LAST	JONES	39	FLSA STATUS	N - NON-EXEMPT
4	EMPLOYEE NAME-FIRST	JOHN	40	PAY LOCATION	001
5	EMPLOYEE NAME-MIDDLE		41	RURAL CARRIER-ROUTE	
6	MAILING ADDRESS STREET/BOX/APT	124 FIRST STREET	42	RURAL CARR-LEVEL ID	
			43	RURAL CARR-PAY TYPE	
7	MAILING ADDRESS-CITY	BALTIMORE	44	RURAL CARR-TRI-WEEKLY	
8	MAILING ADDRESS-STATE	MD	45	RURAL CARR FLSA	
9	MAILING ADDRESS-ZIP+4	21231-1216	46	RURAL CARR-COMMIT	
10	DATE OF BIRTH	02-26-55	47	RURAL CARR-END	
11	VETERANS PREFERENCE	1 - NO PREFERENCE	48	RURAL CARR-HOURS	
12	SEX		49	RURAL CARR-MILES	
13	MINORITY		50	JOB SEQUENCE	
14	DISABILITY		51	OCCUPATION CODE	2148-[illegible]
15	LEAVE COMP DATE	02-05-79	52	POSITION TITLE	GEN CLK
16	ENTER ON DUTY DATE	02-05-79	53	LABOR DIST CODE	6900
17	RETIREMENT COMP DATE	02 05-79	54	DESIGNATION/ACTIVITY	11/0
18	SERV ANNIVERSARY FYYR	04-79	55	POSITION TYPE	1 - FULL TIME
19	TSP ELIGIBILITY	8-ELIGIBLE W/O DEDUCT	56	LIMIT HOURS	
20	TSP SERVICE COMP DATE		57	ALLOWANCE CODE	
21	PRIOR CSRS SERVICE		58	EMPLOYMENT TYPE	
22	PRDEN CSRS TIME		**SALARY INFORMATION**		
23	LEAVE DATA-CATEGORY	B- HOURS/PT	59	PAY RATE CODE	A - ANNUAL RATE
24	LEAVE DATA-CHG FYYR	04-94	60	RATE SCHEDULE CODE	P - PS
25	LEAVE DATA-TYPE	L -ADVANCED AT BEGINNING	61	GRADE/STEP	05/D
26	CREDIT MILITARY SERV		62	SALARY	36,031
27	RETIRED MILITARY		63	COLA	
28	RETIREMENT PLAN	1 - CSRS	64	COLA ADJ-SH IND	
29	EMPLOYEE STATUS	NC - NRIMS EXMP PERMN EMP	65	NEXT STEP FYYR	
30	LIFE INSURANCE	C - BASIC COVERAGE ONLY	66	NEXT ANNIV DATE	
31	SPECIAL BENEFITS		67	PERF LUMP SUM	
POSITION INFORMATION			68	SPECIAL SALARY CODE	
32	EMPLOY OFFICE-FIN NO	23-0378	69	PROTECTED RSC	
33	EMPLOY OFFICE NAME	BALTIMORE/AD'S	70	PROTECTED GRADE/STEP	
34	EMPLOY OFFICE-ADDRESS	BALTIMORE MD 21733-9998	71	EXPIRATION FYYR	
			72	PROTECTED PC HOURS	
35	DUTY STATION-FIN NO	23-0378	73	PROTECTED PC RATES	
36	DUTY STATION-NAME	BALTIMORE/AD'S	74	PC DANGERFIELD SALARY	
37	APPT EXPIRATION DATE		75	ANNUITY AMOUNT	
38	PROBATION FYYR DATE		76	RED CIRCLE CODE	0

NATURE OF PERSONNEL ACTION

77	NATURE OF ACTION CODE	16	78	AUTHORITY				39 USC Sec 1001			
79	DESCRIPTION	REINSTATEMENT WITHIN 1YR	80	CODE		CODE		CODE		CODE	
81	REMARKS	REGLII.									

85	AUTHENTICATION VICK, PRESIDENT, ANNA OPERATIONS	86	PROCESSED DATE	12-28-95
		87	PERSONNEL OFFICE ID	
		88	OPF LOCATION	

PS FORM 50. MARCH 1994 (EXCEPTION TO STANDARD FORM 50)

Exhibit 11.11b
Sample Form 50 Actions (continued)

1	EFFECTIVE DATE	NOTIFICATION OF PERSONNEL ACTION	2	SOCIAL SECURITY NUMBER
	12-22-95			111-00-1225

EMPLOYEE INFORMATION

3	EMPLOYEE NAME-LAST	JONES	50	PLSA STATUS	N-NON-EXEMPT
4	EMPLOYEE NAME-FIRST	JOHN	49	PAY LOCATION	001
5	EMPLOYEE NAME-MIDDLE		41	RURAL CARRIER-ROUTE	
6	MAILING ADDRESS STREET/BOX/APT	924 FIRST STREET	42	RURAL CARR-L-PYE SO	
7	MAILING ADDRESS-CITY	BALTIMORE	43	RURAL CARR-PAY TYPE	
8	MAILING ADDRESS-STATE	MD	44	RURAL CARR-PRO-WEEKLY	
9	MAILING ADDRESS ZIP+4	21211-1234	45	RURAL CARR FLSA	
10	DATE OF BIRTH	07-26-55	46	RURAL CARR-COMMIT	
11	VETERANS PREFERENCE	5-MIL SERVICE	47	RURAL CARR-EMS	
12	SEX		48	RURAL CARR-HOURS	
13	MINORITY		49	RURAL CARR-MILES	
14	DISABILITY		54	JOB SEQUENCE	1
15	LEAVE COMP DATE	02-05-79	53	OCCUPATION CODE	2340-0178
16	ENTER ON DUTY DATE	02-05-79	82	POSITION TITLE	HRM CLK
17	RETIREMENT COMP DATE	02-05-79	83	LABOR DIST CODE	A9HD
18	SERV ANNIVERSARY YR+M	06-79	84	DESIGNATION/ACTIVITY	11/01
19	TSP ELIGIBILITY	E-PARTICIPATE W/O DEDUCT	55	POSITION TYPE	1 - FULL TIME
20	TSP SERVICE COMP DATE		56	LIMIT HOURS	
21	PRIOR CSRS SERVICE		57	ALLOWANCE CODE	
22	FROZEN CSRS TIME		58	EMPLOYMENT TYPE	
23	LEAVE DATA-CATEGORY	5-HOURS/PP		**SALARY INFORMATION**	
24	LEAVE DATA-CHG PAYP	06-94	59	PAY RATE CODE	A-ANNUAL RATE
25	LEAVE DATA-TYPE	1-ADVANCED AT BEGINNING	60	RATE SCHEDULE CODE	1-PS
26	CREDIT MILITARY SERV		61	GRADE/STEP	05/0
27	RETIRED MILITARY		62	SALARY	36,091
28	RETIREMENT PLAN	1-CSRS	63	COLA	
29	EMPLOYEE STATUS	3-RETNS COMP CURRNT EMP	64	COLA ROLL IN CHG	
30	LIFE INSURANCE	C BASIC COVERAGE ONLY	65	NEXT STEP PAYP	
31	SPECIAL BENEFITS		66	NEXT ANNIV DATE	
	POSITION INFORMATION		67	NEXT LUMP SUM	
32	EMPLOY OFFICE-FIN NO	73-0178	68	SPECIAL SALARY CODE	
33	EMPLOY OFFICE-NAME	BALTIMORE/ADO'S	69	PROJECTED RSC	
34	EMPLOY OFFICE ADDRESS	BALTIMORE MD 21201-9998	70	PROJECTED GRADE/STEP	
			71	EXPIRATION PAYP	
35	DUTY STATION-FIN NO	21-0378	72	PROJECTED PC HOURS	
36	DUTY STATION-NAME	BALTIMORE/ADO'S	73	PROJECTED PC MILES	
37	APPT EXPIRATION DATE		74	PC GUARANTEED SALARY	
38	PROBATION EXPIR DATE		75	ANNUITY AMOUNT	
			76	REP CIRCLE CODE	

NATURE OF PERSONNEL ACTION

22	NATURE OF ACTION CODE	925	78	AUTHORITY				79-USE Read Only			
23	DESCRIPTION	REASSIGNMENT (CAO)	81	CODE		80	CODE	82	CODE	83	CODE
24	REMARKS										

85	AUTHORIZATION	86	PROCESSED DATE	12-28-95
	VICE PRESIDENT, AREA OPERATIONS	87	PERSONNEL OFFICE ID	
		88	OPF LOCATION	

PS FORM 50, MARCH 1988 (EXCEPTION TO STANDARD FORM 50)

Exhibit 11.11c

OPM Notification of Reemployment of a Disability Annuitant

With Variants for Full- and Part-Time Employees

RETIREMENT OPERATIONS CENTER
OFFICE OF PERSONNEL MANAGEMENT
PO BOX 45
BOYERS, PENNSYLVANIA 16017-0045

RE:___[name of employee]_____

DOB:_____
SSN:_____
CSA No:_____
OWCP No:_____

The above-referenced former employee has disability annuitant status with your office and has been receiving workers' compensation payments from the Department of Labor.

Mr./Ms.___[name]___ has accepted a job offer with the U.S. Postal Service under the provisions of the Joint USPS/DOL Rehabilitation Program. Mr./Ms. ___[name]__'s reemployment will be effective on __[effective date]___. Attached for your records are a copy of the results of the pre-reemployment medical examination (PS Form 2485) and a copy of the Standard Form 50, *Notification of Personnel Action.*

[Applies to employees who will be working full-time and whose compensation will be terminated upon reemployment:]
Since Mr./Mrs. ___[name]___ will be working on a full-time basis in a position of equivalent grade and pay to the one he/she occupied at retirement, we are requesting an administrative finding of recovery retroactive to his/her date of reemployment. This determination is made in accordance with Chapter 102 of the *OPM Operating Manual* 830-1. Retirement contributions will be withheld from the employee's salary.

[Applies to employees who will be working part-time and who will continue to receive compensation because of loss of wage-earning capacity (LWEC):]
Since Mr./Mrs. ___[name]___ will be working on a part-time basis and will continue to receive compensation from the Department of Labor for loss of wage-earning capacity, we have determined the position is not equivalent in grade or pay to the one he/she occupied at retirement. In view of this determination, we have informed Mr./Mrs. ___[name]___ of his/her status as a reemployed annuitant.

We have further advised Mr./Mrs. ___[name]___ that he/she will retain his/her right to the disability annuity and may elect to receive this annuity upon separation and termination of compensation.

We have also advised him/her that he/she will be entitled to a supplemental annuity based on the period of reemployment if he/she works the equivalent of at least 1 year full time and the option of having the annuity redetermined if he/she works the equivalent of at least 5 years full time. This determination has been made in accordance Chapter 102 of the *OPM Operating Manual* 830-1.

Please note that the standard retirement deductions ___[will/will not]___ be withheld from Mr./Ms. ____[name]___'s salary. (Federal Employees' Retirement System contributions are mandatory; Civil Service Retirement System contributions are optional.)

If further clarification is required, please contact the undersigned on ___[telephone number]___

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

Attachments: Form 2485
Form 50

cc: Personnel Services Office
OWCP Claims Examiners

Exhibit 11.16a

Sample Letter: Post-reemployment or Reassignment Employee Interview

Interviewed by:_____ Date: _____

Employee Name:_____ Date of Reemployment:_____

SSN: _____ Phone:_____

Facility Name: _____ Phone:_____

Address:_____

Position Assigned: _____
Title Grade Step Salary

Work Schedule: _____
Tour Time Days Off

Accommodation or modifications made to the position for the employee:

_____

_____

1. How does employee feel about returning to work?

2. What is the attitude of the employee toward:
   a. Immediate supervisor?
   b. Co-workers?

3. Has employee experienced any difficulty in adjusting to the work environment?

4. Has employee experienced any health or medical problems? If yes:
   a. What are the problems?
   b. Did employee have this medical condition examined by the postal medical officer or outside treating physician?
   c. What was the date of treatment and result of the examination?

5. Does employee have any other comments or suggestions regarding the Rehabilitation Program?

cc: ___[appropriate functional]___ Manager
Area Human Resources Analyst
OWCP Rehabilitation Counselor
File

Exhibit 11.16b

Sample Post-reemployment or Reassignment Supervisor Interview

Interviewed by:_____ Date:_____

Supervisor Name:_____ Title: _____

Employee Name/_____ Date of Reemployment:_____

SSN:_____

Facility Name:_____ Phone:_____

Position Assigned: _____
Title Grade Step Salary

Work Schedule: _____
Tour Time Days Off

Accommodation or modifications made to the position for the employee:

_____

1. How does the supervisor assess the employee's attitude toward:
   a. Current position?
   b. Work environment?
   c. Co-workers?

2. Has the employee been absent since his or her reemployment or reassignment? If yes, list dates and reasons (if known).

cc: ___[appropriate functional]___ Manager
Area Human Resources Analyst
OWCP Rehabilitation Counselor
File

Exhibit 11.21

Sample Letter: Termination of Limited Duty Assignment for Refusal of In-House Rehabilitation Program Job Offer

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject:
To: ___[name]___
___[street address]___
___[city, state, ZIP Code]___

File No. ___[OWCP case number]___
Certified No._____

Dear Mr./Ms. ___[employee's name]___:

This is in further reference to our job offer letter, dated ___[date]___.

By the above letter, you were offered permanent reassignment under the provisions of the Rehabilitation Program. You were advised that this assignment was in strict compliance with your medically defined permanent work restrictions, and requested to respond by _[date]_. [As of the date of this letter, you have failed to respond. On _[date of employee response]_, you advised that you were refusing the job offer]. This office believes your refusal is invalid for the following reason(s):

___[Respond to employee's reasons for refusal (if any were given)]___.

The purpose of the limited duty program is to accommodate the *temporary* partial disabilities of injured-on-duty employees. Since your disabilities have now been medically defined as being permanent, you are no longer eligible for participation in the limited duty program. However, your limited duty assignment will continue pending OWCP's suitability determination on the rehabilitation job offer.

Please be aware that OWCP will be advised that you were offered a permanent assignment in accordance with your work limitations and that such assignment will remain available until a decision is rendered by OWCP.

If you have any questions or wish to reconsider the offered position, please contact the senior injury compensation specialist on __[telephone number]__.

Sincerely,

___[signature]___
___[name]___
Manager, Human Resources

12. Records Management

Overview

Procedures

Injury Compensation Case Files

When you establish the IC office record system...

Obligation: Case Files and the Privacy Act
The Privacy Act of 1974

12.1 Ensuring That Privacy Act Requirements Are Met . . . . . *senior IC specialist*

12.2 Establishing Files . . . . . *ICCO*

12.3 Maintaining and Closing Files . . . . . *ICCO*
Factors Considered in Record Retention

12.4 Using Logs, Registers, and Reports . . . . . *senior IC specialist*

12.5 Maintaining Logs, Registers, and Reports . . . . . *ICCO*

Individual Case Files

When an employee submits an injury claim...

12.6 Preparing an IC Case File . . . . . *ICCO*

Disclosure Request

When requests are made for information contained in IC files...

12.7 Determining Whether the Requester May Be Allowed Access to the Records . . *ICCO*
Employee Records

Disclosure Denied

When the requester may not be allowed access to IC files...

12.8 Denying Access to IC Files . . . . . *ICCO*

Disclosure Granted

When the requester may be allowed access to IC files...

12.9 Granting Access to IC File Information by Telephone . . . . . *ICCO*
Public Information

12.10 Granting On-Site Access to IC File Information . . . . . *ICCO*

12.11 Granting Access to IC File Information by Mail . . . . . *ICCO*

Obtaining Information Not Found in Files

When pertinent information is not submitted with the claim...

12.12 Requesting Materials From the Medical Unit . . . . . *ICCO*

12.13 Requesting Materials From OWCP Claim Files . . . . . *ICCO*
12.14 Requesting Permission to Inspect OWCP Claim Files . . . . . *senior IC specialist*

Exhibits

12.1a Disclosure Conditions
12.1b Injury Compensation Privacy Act Log of Accounting of Disclosure
12.4 Injury Compensation Computer Systems
12.8 Noncompliant Response to a Subpoena

12. Records Management

Overview

This chapter explains the administrative system that the ICCO must establish to ensure proper handling of records kept to reflect the status of all claims and to ensure compliance with the Privacy Act. It also provides an overview of the HRIS, the WCIS, and the Workers' Compensation Information Reporting System (WCIRS). (For step-by-step procedures on how to use these systems, see the *WCIS/WCRIS Reference Guide,* January 1995.)

Under FECA, all records, medical and other reports, statements of witnesses, and other papers relating to the injury or death of a civil employee of the United States or other persons entitled to compensation or benefits from the United States under FECA, and all amendments and extensions thereof, are the official records of OWCP. They are not records of the agency, establishment, or department making or having the care or use of such records. (20 CFR 10.10)

These records are contained within a government-wide system of records under the control of DOL. The regulations of the agency in possession of such records, however, govern the procedure for requesting access to or amending the records. The ICCO, consequently, is responsible for the maintenance, disclosure, and disposition of injury compensation program records within the USPS consistent with the Privacy Act. (FECA, 20 CFR 10.12, and 29 CFR 70a.1(b)(3))

The ICCO maintains three types of program records. Individually identifiable information within two of these types, case files and claims status records, must be collected, used, disclosed, and safeguarded in compliance with Privacy Act regulations found in the ASM 353.

— *Case files*. The ICCO prepares a case file for each new claim it receives. These files consist of all relevant claim forms, medical documentation, correspondence, and any other pertinent information. These files contain sensitive information regarding the injured claimant.

— *Claim status records*. These records consist of logs and reports that relate to the status of claims, e.g., Inspection Service Referral Report, Third Party Log, etc. These records contain information that identifies individual claimants.

— *Program administration and general office records*. These records relate to the general administration and internal operations of the ICCO, e.g., directives, general reports, etc. These records do not contain individually identifiable information.

Many of the logs and reports are available through HRIS, WCIS, and WCIRS. HRIS should be used to gather pertinent IC data whenever possible for effective claims management. *Manual logs should only be used in cases where there is no electronic capture of data under HRIS available.*

Procedures

Injury Compensation Case Files

When you establish the IC office record system...

Obligation: Case Files and the Privacy Act

IC case files are maintained to monitor the administration of benefits under FECA, as amended, which covers all officers and employees of the USPS. IC records are maintained by the USPS within the Privacy Act system of records identified as USPS 120.098 (OWCP Records Copies).

Privacy Act regulations apply to all IC case files and claim status records (identified as USPS 120.099), including those that are computerized. These files and records are, therefore, to be treated as restricted and given the same measure of security as other personnel records systems.

Postal Service regulations implementing the Privacy Act are found in ASM 353. Descriptions of Privacy Act systems of records USPS 120.098 and 120.099 are found in the ASM Appendix.

The Privacy Act of 1974

The Privacy Act of 1974 provides safeguards for individuals against invasion of personal privacy. It provides criminal penalties, including fines up to $5,000 for any officer or employee of a federal agency who, knowing that disclosure is prohibited, willfully discloses information about an individual to any person or agency not entitled to receive it. In addition, the Privacy Act provides criminal penalties for any person who knowingly and willfully requests or obtains under false pretense any record from a federal agency concerning another individual.

12.1 Ensuring That Privacy Act Requirements Are Met — *senior IC specialist*

- ☐ Ensure that files and records containing identifiable information are stored in locked cabinets, and secure those cabinets when the records are not in use.
- ☐ Ensure that computerized information is password-protected and not left unattended on screens.
- ☐ Familiarize staff with necessary precautions to ensure that file information is disclosed only to individuals with proper authorization (see Exhibit 12.1a, Disclosure Conditions).
- ☐ Ensure that an accurate accounting is maintained of every disclosure of information from a system of records *except* for:

- — Information disclosed to the file subject.
- — Information disclosed to USPS employees for use in the performance of their duties.
- — Information that is public under the Freedom of Information Act.

□ Records of correspondence in many instances satisfy Privacy Act requirements, but the ICCO staff, at the discretion of the manager, can also maintain a log for accounting of disclosure in each file (see Exhibit 12.1b, Injury Compensation Privacy Act Log for Accounting of Disclosure).

◇ *For retention period for accounting of disclosure, see ASM 353.3*

12.2 Establishing Files — *ICCO*

☐ Prepare a separate folder for each new injury or illness reportable to OWCP and place files alphabetically in file cabinet according to employee's last name. (A color-coded system may be helpful to identify the type of claim CA-1, CA-2, CA-5/5b, third party pursuits, etc.)

☐ For nonreportable traumatic injury cases, maintain the original CA-1 claim form in the employee's OMF, if it is available, or in the employee's OPF.

◇ *If the CA-1 is maintained in the OPF, the CA-1 and any medical documentation must be kept in a sealed envelope within the OPF.*

☐ File claims for recurrences (CA-2as) in the same folders with the original injuries or illnesses.

☐ If OWCP combines two or more of an employee's claims (as often happens when an employee has multiple new injuries to the same part of the body), process the claims as one and identify them with one OWCP file number.

Annotate the involved files and keep the claim files together. This can be accomplished by various means, depending on the size of the individual files and available material, e.g.:

— Use one folder and insert dividers, correctly labeled, separating the individual claim documents that were processed before the claims were combined.

— Establish a master folder and fasten it together with the other claim folders using large rubber bands.

— Establish a master folder and place all involved case files in an expandable folder.

☐ When an employee with an IC case file is reassigned to another postal facility in a different geographic area, transfer the file, via certified mail, to the appropriate ICCO and retain a copy of the transmittal letter in the general administrative file.

12.3 Maintaining and Closing Files — *ICCO*

Factors Considered in Records Retention

Receiving compensation, for purposes of records retention, is defined as any payments (wage loss and medical) made by OWCP. Moreover, the case is considered active when an employee is working in a limited duty status in lieu of receiving compensation for wage loss.

The end of the fiscal year from the effective date of termination of all FECA benefits is the cutoff date for file retention purposes.

When employee compensation is terminated (no wage loss, no medical payments, and no limited duty), the case file must be placed in inactive files, retained for 5 years, and then destroyed.

- ☐ Retain active files at the local ICCO as long as the employee or survivor is in receipt of FECA benefits (wage loss or medical payments or limited duty).
- ☐ Once FECA benefits cease, cut off the file at the end of the fiscal year and move the case folder to the inactive file for 5 years. Do not send the files to a national files retention center (NFRC).
- ☐ Review inactive files at the end of each fiscal year to verify that each file has been inactive during the year.
- ☐ Destroy by shredding or burning files that have remained inactive for 5 years from date of cutoff.

12.4 Using Logs, Registers, and Reports — *senior IC specialist*

□ Track cost and forecast trends over specified periods of time by using the logs, registers, and reports available via the reporting systems (see Exhibit 12.4, Injury Compensation Computer Systems).

◇ *Accurate data are essential in order to provide facts on a particular case or information about the overall IC Program.*

□ Familiarize staff with aids that can assist them in the performance of their tasks. The following are used most often in day-to-day claim and program management:

— Available via HRIS:

– *Call-up Messages*. Use this register to provide a list of suspended items that require attention on a specified date. *The daily use of this register is vital to ensuring good claims management.*

– *Injury Claim Log*. Use this log, a master journal of all claims filed, in the preparation of various reports and responses to inquiries. It is available on demand.

– *Claim Control Register*. Use this individual case register to provide an up-to-date picture of the status of a case. Generate the register from the basic format available on demand, place it on the left-hand side of the case file, and update it manually.

– *Controversion/Challenge Status Report*. Use this report, available on demand, to identify cases awaiting OWCP decisions.

– *Rehabilitation Program*. Use this log to identify employees on OWCP's rolls and track job offers and results.

– *Injury Compensation Activity Summary (ICAS).* Use this report to track and summarize program activity. The information in this report is used by all levels of management to access program trends and activities.

— Available via WCIS:

– *Chargeback Report*. Use this report, which reflects the dollar amounts DOL OWCP is charging back to the USPS for monies disbursed under FECA provisions, to provide data useful in planning the budget, initiating rehabilitation efforts, and evaluating the cost of injuries. Updated every accounting period, the Chargeback Report is a primary cost indicator used by all levels of management.

— From the MISSC:

– *Workers' Compensation-Injury on Duty Report (WC-IOD)*. Use this report, automatically generated every accounting period, to gain awareness of both hours and cost of the COP and LWOP-IOD being entered into the USPS payroll system. This cost report, along with the dollar amounts reflected on the chargeback, provides a good picture of the overall cost of injuries.

12.5 Maintaining Logs, Registers, and Reports — *ICCO*

☐ Maintain accounting of disclosure logs with the related records and dispose of them with those records or after 5 years, whichever is longer.

☐ Maintain other logs, registers, and reports on a fiscal year basis, cutting off inactive documents each fiscal year. It is not necessary to retain complete copies of all management reports. Some management reports consist of summaries as well as detailed information. Dispose of logs, registers, reports, and summaries 10 years after date of cutoff.

☐ Update the Injury Compensation Activity Summary or HRIS each accounting period.

☐ Review the Chargeback Report or WCIS carefully each accounting period. If you find that an erroneous payment is covered, submit a written request to OWCP to correct the error. Such requests must be accompanied by supporting documentation.

◇ *When local efforts fail to correct the error, refer the matter to the designated area HR analyst.*

☐ Review the Workers' Compensation Injury on Duty Report for the MISSC carefully each accounting period. If you discover errors, notify the area HR analyst or Headquarters IC specialist, in writing, to initiate corrective action.

Individual Case Files

When an employee submits an injury claim...

12.6 Preparing an IC Case File — *ICCO*

☐ Establish an IC case file for each employee who submits an injury claim. Upon receipt of the claim form, set up a file, using a sturdy file folder with two-pronged fasteners on both sides. Do not use OPFs.

☐ Prepare the label and include the following information:

a. Employee's name: last, first, middle initial.

b. Date of injury.

c. Social Security number.

d. Type of claim form filed.

e. Name of station or post office.

f. Nature of injury.

Example:

Coleman, Ray T. DOI: 06/05/95
233-42-5555 CA-1
Penn Pines Sta Low Back

☐ Provide additional information to assist the ICCO in locating files within the local office's system (color coding, e.g.).

☐ Generate the appropriate claims management aids from HRIS and place on the left-hand side of the folder. Available aids consist of:

— *Claim Control Register*. This register provides basic information regarding the injury and space for activity notes.

— *COP Tracking Log*. This log allows for tracking COP by date and accounting period. It also provides space for entering the actual number of COP hours used per day. In addition, a comments column allows for entering information such as holiday pay, medical care, etc.

— *Claim Activity Tracking Log*. This log is specifically designed to keep track of all correspondence, forms, etc. It provides space for entering the date, description and suspense date (if any) for each action.

— *Privacy Act Disclosure Log*. (See 12.1b, Injury Compensation Privacy Act for Accounting of Log Disclosure.)

☐ Arrange claim documents in the folder chronologically from bottom to top on the right-hand side of the folder. A copy of the originating claim form (CA-1, CA-2, CA-5 and CA-5b) should always be on the bottom.

Keep only copies of claim forms and medical reports pertaining to a FECA claim in the ICCO case file.

File documents may include, but not be limited to:

— All pertinent CA forms (CA-1, 2, 7, 8, 16, 17, 20, etc.).

— All pertinent medical reports.

— All pertinent PS forms (third party recovery forms; Form 1769, *Accident Report*; etc.) and form letters.

— Correspondence.

— Investigative reports.

◇ *Do not maintain uncirculated personal notes with the case file or any file that is accessible to other persons.*

☐ Forward the originals of pertinent CA forms, medical reports, pertinent investigative reports, and correspondence to the OWCP district office.

☐ Place the file alphabetically in the file cabinet according to the employee's last name.

Disclosure Request

When requests are made for information in IC files...

12.7 Determining Whether the Requester May Be Allowed Access to the Records — *ICCO*

Employee Records

Records related to an employee's injury or illness are sensitive and must be protected from unauthorized access and disclosure. These records are in the exclusive custody of ICCO personnel, and disclosure is made directly from ICCO to the requester.

☐ Determine whether the individual requesting the information may be allowed access to the information requested (see ASM Appendix and Exhibit 12.1a, Disclosure Conditions, for information that will help in the decision).

☐ If the request is for Inspection Service Records, refer the requester to the chief postal inspector (see ASM 353.324a).

☐ If the request is for medical or psychological records, contact the postal or contract medical provider or OHNA to determine if disclosure of any portion of the records could have an adverse effect on the individual. When such a determination is made, respond according to the type of requester:

— If the request is from an employee, prepare a written response advising the requester that:

  – Because of the nature of the requested medical information, the documentation cannot be provided directly to the employee.

  – Upon the employee's written authorization, however, the requested information will be provided to his or her representative or personal treating physician.

  – The employee has the right to appeal the withholding of this information to the USPS General Counsel.

— If the request is from a union official other than the employee's authorized representative, immediately consult with Labor Relations. In some instances, a summary prepared by the contract medical provider or the OHNA may be sufficient to respond to the union request.

— If the request is from a judge who requests release of medical information via court orders or subpoenas, immediately consult the chief field counsel. When it is determined that the records must be released, a cautionary statement must be included as to the possible adverse effect that would result if information from the record were made known to the subject or to the public. This statement is prepared by either the contract medical provider or the OHNA.

Disclosure Denied

When the requester may not be allowed access to IC files...

12.8 Denying Access to IC Files — *ICCO*

☐ If the requester asks for information that cannot be disclosed or does not have the required authorization (see ASM Appendix and Exhibit 12.1a, Disclosure Conditions), send a response to the requester advising why the requested documents cannot be provided, adapting as follows if necessary:

— If the request is in the form of a subpoena, a more detailed response is required to explain that a court order signed by a judge is required (see Exhibit 12.8, Noncompliant Response to a Subpoena, for a sample letter).

— If the requester is the file subject or a representative with written permission from the file subject, consult with the chief field counsel before notifying the requester of the denial. Prepare a written response to the requester including:

– Reason for the denial.

– Advisement of appeal rights. The requester has a right to appeal the denial to the General Counsel at USPS Headquarters.

Disclosure Granted

When the requester may be allowed access to IC files...

12.9 Granting Access to Injury Compensation File Information by Telephone — *ICCO*

☐ If the requester is an individual seeking information that is public under the Privacy Act or a postal employee known to you who requires IC claim information in the performance of postal duties, ask for a Social Security number, OWCP file number, or other specific information that will provide positive identification. Provide the information when you are satisfied.

Public Information

The name, job, title, grade, salary, duty status, and/or date of postal employment of any current or former employee are public information under the Freedom of Information Act and may be disclosed to any person without requiring employee authorization or logging the request. Other information contained in IC case files is, for the most part, exempt from public disclosure.

12.10 Granting On-Site Access to IC File Information — *ICCO*

☐ Establish the identity of the requester.

☐ If the request is from the file subject or another authorized individual:

— Inform the requester that:

– Postal employees who wish to review any of their own records must do so on their own time, except as provided for under current collective bargaining agreements.

– Records are available for inspection and copying during normal ICCO business hours.

– A complete official file can be obtained from the OWCP district office.

— Schedule an appointment with the requester for the earliest possible date but not more than 10 working days from the date of request.

— Before the scheduled appointment, review the file to ensure that the file is in proper order.

— If the file subject is accompanied by another individual, have the file subject sign a statement that he or she authorizes a representative to be present during his or her review of the specific record or records.

— Allow the file subject and/or his or her authorized representative to review the file in your presence or that of another ICCO staff person. The ICCO representative must maintain control over the official record.

☐ If requested, make copies (either the ICCO representative or the reviewer in the presence of the ICCO staff person).

Furnish without charge the first 100 pages in response to a request from anyone other than a postal employee in performance of postal duties. After that, a fee of 15 cents per page may be charged for duplicating any record. Copying fees collected as a result of Privacy Act requests are deposited in AIC 127.

12.11 Granting Access to IC File Information by Mail — *ICCO*

- ☐ Respond in writing to any authorized individual requesting records by mail.
- ☐ If the disclosure is in response to a subpoena, court order, or other demand for testimony or records, contact the office of the chief field counsel immediately for instructions.
- ☐ Send all records that may be disclosed (see Exhibit 12.1a, Disclosure Conditions) within 10 working days.
- ☐ Furnish without charge the first 100 pages in response to a request from a file subject or his or her representative. After that, a fee of 15 cents per page may be charged for duplicating any record. Copying fees collected as a result of Privacy Act requests are deposited in AIC 127.

Obtaining Information Not Found in Files

When pertinent information is not submitted with the claim...

12.12 Requesting Materials From the Medical Unit — *ICCO*

☐ To obtain medical documentation relevant to an IC claim (e.g., information regarding a preexisting condition) that remains in the employee's medical folder, prepare a written request to the medical unit in care of the respective OHNA stating the specific record or information being requested and the reason for needing it.

12.13 Requesting Materials From OWCP Claim Files — *ICCO*

☐ To obtain copies of materials from OWCP claim files, submit a request in writing, through the area HR analyst, to the appropriate claims examiner. Identify yourself and state the reason you are requesting the information. Once it is received, the material becomes part of the IC case file and access is limited.

12.14 Requesting Permission to Inspect OWCP Claim Files — *senior IC specialist*

☐ To request that a designee be permitted to inspect files at the OWCP district office, submit a request to the OWCP district director well in advance of the planned visit. The letter should:

- Request confirmation of the planned visit date(s).
- Provide a list of the cases to be reviewed.
- State the purpose of the review.
- Identify the reviewer(s).

Upon arrival at the OWCP district office, reviewers must present picture identification.

The above procedures are not normally required for designated liaisons (e.g., designated area HR analysts) once proper identification is established.

Exhibit 12.1a

Disclosure Conditions

Full information on Privacy Act requirements for disclosure of information kept in the official record series is found in ASM 353 and Appendix, section C. The following provides general guidelines.

If requester is...	With required...	Accounting must be kept...*	This information can be disclosed...
Public	Verbal identification of employee with SSN, OWCP claim number, or other specific identifier	No	Name, job, title, grade, salary, duty status, dates of postal employment of file subject
Postal employee in performance of postal duties	Proper verbal statement of position and need	No	Information in file relative to official need
Routine user (individual with externally authorized access as defined in ASM Appendix, section C)	Written request on letterhead, signed by agency official, specifying need *If the routine user is a union representative other than the employee's authorized representative, the request should be screened by Labor Relations (LR). The senior IC specialist should confer with LR to determine local protocol for reviewing files.*	Yes	
File subject (individual to whom file pertains)	Identification in person or signed request by mail	No	Information in file relative to the request ***except*** : — The name of or information identifying an individual who has expressly requested anonymity — Records compiled in reasonable anticipation of civil action or proceeding, such as a lawsuit or administrative hearing — Records of the disclosure of information to law enforcement agencies for civil or criminal law enforcement purposes — Psychological and other sensitive medical and records. — Uncirculated personal notes with information pertaining to individuals
Representative of file subject	Written authorization from the file subject	Yes	
Other requester without file subject's consent, including spouse but other than postal employee in performance of duty or routine user as defined in ASM	One of the following: — A court order signed by a judge directing the USPS to disclose the records — Compelling evidence from the requester that the health or safety of the file subject is affected, with notification sent to the last known address of file subject	Yes	Information in file relative to court order or compelling need

* Correspondence meets ASM requirements for accounting, but logging of requests suggested (see 12.1).

Exhibit 12.1b

Injury Compensation Privacy Act Log for Accounting of Disclosure

USPS Record System

Personnel Records — OWCP Record Copies, 120.098, and Injury Compensation Payment Validation Records, 120.099

(See ASM 353.3)

Name of Claimant	FECA Claim No.	Requester and Address	Purpose and Listing of Items and/or Data Disclosed	Date Provided

Exhibit 12.4
Injury Compensation Computer Systems

Human Resources Information System

The IC module is part of the national HRIS. The primary objective of the module is to improve the ability of local ICCOs to track and control IC claims.

The module provides detailed tracking of every on-the-job injury case, including local first-aids cases. It creates logs and reports that eliminate the need for manual logs and aids in evaluating injury activities. It ensures data integrity by comparing the WCIS and safety and IC databases. If there is a discrepancy, the system creates an exception to advise you. The module also provides an automatic tickler system in the form of system messages called call-ups. These messages are scheduled case activities for specific dates in the future. The messages assist you in providing timely return to work of recovered employees, timely settlement of third party cases, and a great deal more.

One of the benefits of a national system is that information such as employee name, address, job assignment, years of service, OWCP case status, etc. are provided from other existing HRIS and WCIS subsystems. Also, multiple people can access the same injury record at the same time. Local injury data are rolled up to the area and national levels to provide the total number of ICCO activities taken, servicewide injury trends, through the ICAS report generated each accounting period.

For more information, see the *Injury Compensation System User's Guide.*

Workers' Compensation Information Subsystems

WCIS is considered a valuable management tool in controlling and reducing compensation costs and monitoring injury claims activities. The WCIS is a database that contains current information on all postal injury claims, including compensation and medical payments, made to or on behalf of postal employees by the DOL, OWCP. Additionally, the data contained in the WCIS are used by Headquarters and the area offices to generate various management reports. This information is updated weekly at the MISSC with computer tapes furnished by the OWCP and is available for online query by IC personnel and postal inspectors assigned to the investigation of IC claims for fraud or abuse.

In WCIS, all open OWCP cases filed by USPS employees and all cases closed less than 2 years can be viewed. Individual payments made during the past 2 years can also be viewed. After 2 years, this information cannot be viewed by accessing the automated compensation payment system or bill payment system; however, the amount of these payments is always reflected in TOTAL (total payments).

Privacy Act Consideration

The warning “Restricted Information” appears on WCIS screen displays and documents containing sensitive information. All records associated with WCIS applications are subject to USPS policies concerning the Privacy Act, and any questions or correspondence related to disclosures should be referred to the ASM, 352, 353, and Appendix. Relative to the restricted information, computer terminals should be kept in a secured area and should not be left unattended when restricted information is being displayed.

Workers’ Compensation Information Reporting System

Workers’ Compensation Information Reporting System (WCIRS) is an ad hoc reporting system written in FOCUS language in which information is extracted from the WCIS IDMS database. This file is updated every 28 days or when the periodic roll files are received and inputted into the system. Certain menu-driven reports are available and can be easily printed on local printers. A recent enhancement accomplished on the WCIRS is the addition of a reports menu designed specifically to assist the Inspection Service in its review of periodic roll case files. These reports are accessible to all WCIS/WCIRS users.

Types of WCIRS Reports

The WCIRS provides users with the capability of requesting available online reports in three categories:

— Fiscal year payments.

— Reported claims (from 1989 to current year).

— Periodic rolls (current year only).

Other management reports can be generated by individuals skilled in FOCUS programming language using the ad hoc reports menu item on the main menu. Any special requests need to be directed to the Headquarters WCIS/WCIRS Coordinator at 202-268-3685 with the reason for requesting this report. Sufficient time should be given for the programmer to schedule to accommodate the existing work load.

For more information, see the *Workers’ Compensation Information Reporting System (WCIRS) Reference Guide, January 1995.*

Exhibit 12.8

Noncompliant Response to a Subpoena

With Variants for Requests Related to Workers' Compensation Records

[U.S. Postal Service Letterhead]

___[date]___
___[name]___
___[street address]___
___[city, state, ZIP Code]___
Re: [Reference lawsuit identified on subpoena]

Dear ___[name]___:

This letter responds to the subpoena you have served on the U.S. Postal Service in ___[city]___, ___[state]___ seeking disclosure of records regarding a postal employee. For the reasons set forth below, we are unable to release the requested records at this time.

The records that you are requesting are protected from disclosure under the Privacy Act, 5 U.S.C. 552a. The Act prohibits disclosure of such records except in certain specified instances. Generally, in private litigation, the records may only be disclosed pursuant to a release signed by the employee whose records are sought, or "the order of a court of competent jurisdiction" (5 U.S.C. 552a(b)(11)). The federal courts have consistently held that a subpoena signed by an attorney or clerk of court is insufficient to meet the requirements of the Privacy Act *(Doe v. DiGenova,* 779 F.2d 74, 85 (DC Cir. 1985); *Perry v. State Farm Fire & Casualty,* 734 F.2d 1441, 1447 (11th Cir. 1984); *Bruce v. United States*, 621 F.2d 914, 916 (8th Cir. 1980); *Moore v. United States Postal Service*, 609 F.Supp. 681 (E.D.N.Y. 1985); *Stiles v. Atlanta Gas Light Co.,* 453 F.Supp. 798, 800 (N.D. Ga. 1978)). Because the subpoena you have submitted bears only the signature of the ___[clerk of court/attorney]___, and contains no indication of judicial approval, we are unable to release the requested records. However, upon receipt of either an employee release or court order directing disclosure, we will release the record.

[For requests related to workers' compensation records, add the following two paragraphs:]
Additionally, it is noted that some of the requested records may pertain to a job-related injury and the claim for benefits under the Federal Employees' Compensation Act arising therefrom. Such official records are under the exclusive jurisdiction of the U.S. Department of Labor.

A request for authorization to produce these records should be sent to:

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
200 CONSTITUTION AVENUE
WASHINGTON DC 20210-0001

[For requests seeking the appearance of postal officials regarding the contents of employee records, add the following paragraph:]
In addition to documents, you seek testimony of a postal official. To the extent that any information known to him or her about a postal employee was gained through the generation or review of records protected from disclosure by the Privacy Act, the official may not reveal that

information absent a court order or the employee's authorization. Thus, no postal official will appear at the scheduled deposition until you obtain a court order or an authorization from the person who is the subject of your inquiries.

Sincerely,

___[signature]___
___[name]___
Senior Injury Compensation Specialist

13. Timekeeping and Accounting

Overview

Procedures

Continuation of Pay

When an employee chooses COP after sustaining a traumatic injury...

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Obligation: Monitoring COP
COP Entitlement

13.2 Providing COP for Most Full-Time, Part-Time, Transitional, Casual, or Temporary Employees . . . . . *ICCO or designated control point*
Pay During the COP Period

13.3 Providing COP for Employees Being Terminated . . *ICCO or designated control point*

13.4 Recording COP for Most Full-Time, Part-Time, Transitional, Casual, or Temporary Employees . . . . . *ICCO personnel*
Guaranteed Time

13.5 Recording Limited Duty for Most Full-Time, Part-Time, Casual, Transitional, or Temporary Employees . . . . . *ICCO or designated control point*

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Leave and Compensation Administration

When leave or compensation is needed...

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13.12 Recording Absences When Employee Receives Compensation for Wage Loss from OWCP . . . . . *ICCO or designated control point*

13.13 Recording Absences When a Claim Is Pending . . . . *ICCO or designated control point*

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13.19 Processing Leave Buy Back . . . . . *ICCO or designated control point*
Leave Buy Back

13.20 Initiating Health Benefits Refund . . . . . *ICCO or designated control point*
Health Benefits Refund Enhancement to WCIS

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When the employee suffers a recurrence of disability...

Exhibits

13.1 COP/LWOP-IOD Timekeeping Work Sheet

13.6 Regular Rural Routes

13.11 Timekeeping Codes

13.12 Leave Types

13.14a Sample Letter: Personnel Notification — Leave Without Pay

13.14b Sample Letter: Personnel Notification — Return to Duty

13.16 Third Party Court Appearance

13.19a Sample Letter: Leave Buy Back Policy

13.19b Sample Letter: Form Letter CA-1207

13.19c Application for Reinstatement of Leave (EN-1207)

13. Timekeeping and Accounting

Overview

The purpose of this chapter is to provide the ICCO with specific guidelines for proper timekeeping and accounting procedures. These guidelines are essential for effective management and administration of the injury compensation program. Although the administration of compensation and leave administration is addressed, special attention is given to COP.

Public Law 93-416, approved September 7, 1974, significantly revised FECA to provide for continuation of regular pay for a period not to exceed 45 days for certain employees who file a claim for wage loss caused by traumatic injury. Pay received during the COP period is considered regular “income” and not “compensation,” and unlike compensation, it is subject to all taxes and other payroll deductions applicable to regular income.

The intent of the COP provision is to eliminate interruption in the employee’s income during the period immediately following a job-related traumatic injury.

Employees eligible for COP include all current:

— Regular schedule employees, including managers and supervisors.

— Part-time flexible employees.

— Transitional employees.

— Temporary employees.

— Casual employees.

— Rural carriers.

Independent contractors and individuals employed by independent contractors are generally not entitled to COP. See Chapter 4, Claims Management, for information concerning COP eligibility criteria.

Procedures

Continuation of Pay

When an employee chooses COP after sustaining a traumatic injury...

13.1 Tracking Time for COP — *ICCO or designated control point personnel*

Obligation: Monitoring COP

The ICCO must monitor COP hours to ensure that employees do not receive COP for more than a 45-calendar-day period for any one injury.

COP Entitlement

Employees may receive COP for up to 45 calendar days for time lost from work because of disability resulting from a job-related injury provided that absence from work time is medically indicated. Medical documentation to support this absence must be furnished within 10 days from the beginning of disability.

The maximum number of COP hours most employees are entitled to receive per injury is 264. Rural carriers with an H route cannot exceed 312 COP hours; rural carriers with a J route cannot exceed 288 COP hours.

Holidays and scheduled leave are counted as workdays.

An employee's entitlement to COP must be used within 90 days of the DOI, or if there is no immediate time loss, within 90 days of the first time loss following the DOI. The only exception is when continuing days of COP bridge the 90th day. In that case, pay may be continued until entitlement is exhausted or the employee returns to work.

☐ Track employees' COP days as follows:

— Start tracking COP days on the *calendar day* following the first full day or shift the employee is absent from work because of a disabling traumatic injury.

For example, if an employee whose regular work schedule is Monday through Friday, 8:00 a.m. to 4:30 p.m., sustains a disabling injury at 2:00 p.m. Friday, the first day to be charged against the COP entitlement is Saturday rather than the employee's next scheduled workday, even though there is no payment made.

— Continue tracking up to the day the employee returns to work or 45 days is reached, whichever comes first. Include weekends, holidays, and planned leave during that time.

  - For a bargaining unit or FLSA-nonexempt EAS employee, count any day or shift on which the employee requires time off as a full calendar day.
  - For an FLSA-exempt EAS employee, if the employee returns to work part time because of medical limitations or requires time off for treatment of the injury, any portion of the day lost counts as a full day of COP regardless of the FLSA-exempt status.
- — If the employee loses time because of further periods of disability or for medical treatment, start and stop tracking in the same way for each subsequent absence.
- — Ensure that the number of days included within the employee's COP limit does not exceed 45 calendar days within the 90-day entitlement period.

◇ *Only if the injury occurs before the beginning of the workday may the DOI be charged to COP.*

□ Track an employee's COP hours as follows:

- — Count actual hours charged to COP.
- — Ensure that the number of hours charged to COP within the 45-day COP period does not exceed:
  - For a rural carrier with an H route, 312 hours.
  - For a rural carrier with a J route, 288 hours.
  - For other employees, 264 hours.

SEE Exhibit 13.1, *COP/LWOP-IOD Timekeeping Worksheet,* for assistance in tracking days and hours.

SEE Exhibit 13.17, Recovering Excessive COP Hours, for information on monitoring COP.

13.2 Providing COP for Most Full-Time, Part-Time, Transitional, Casual, or Temporary Employees — *ICCO or designated control point personnel*

Pay During the COP Period

Pay during the COP period includes:

— Night shift differential or Sunday premium pay employees would normally receive.

— Holiday pay employees would normally receive (recorded as holiday pay but counted as COP days).

Changes in pay that otherwise would have occurred during the 45-day period (e.g., step, general, or promotion increases, demotion, termination of a temporary detail) are reflected in the COP amount and take effect at the time they normally would have occurred.

☐ Provide COP with Form 3971, *Request for or Notification of Absence*, for different types of employees in the following manner:

— ***Regular schedule employees*** (full-time or part-time employees who work each week for the same number of hours) receive pay for the regularly scheduled hours not worked because of the injury. The amount paid during COP is equal to their current basic rate plus COLA and premium pay, excluding overtime.

$$\textit{COP Rate} = \textit{current basic pay} + \textit{COLA and premium pay (excluding overtime)}$$

— ***Part-time flexible schedule employees*** (employees who work each week, but do not work the same number of hours each week) receive pay at a weekly rate equal to their total earnings, excluding overtime, during the 1 year preceding the DOI (or since appointment, if less than 1 year), divided by the number of weeks during which some earnings were received during that same period.

The amount paid during COP is equal to basic pay plus COLA and premium pay, excluding overtime.

$$\textit{Weekly COP Rate} = \frac{\textit{total earnings during 1 year preceding the DOI, including COLA and premium pay (excluding overtime)}}{\textit{number of weeks that earnings were received during the year}}$$

The calculated weekly pay rate is prorated for any partial weeks of eligibility: for each day, an amount equal to the weekly pay, less any regular pay received for the week, divided by the number of days that have not been worked.

$$\textit{Daily COP rate} = \frac{\textit{calculated weekly pay less any regular pay received for the week}}{\textit{number of days not worked during the same period}}$$

However, the weekly pay may not be less than 2.9 times the average daily pay received during the 52-week period immediately preceding the DOI.

$$\textit{Average daily pay} = \frac{\textit{total earnings during the 1 year preceding the injury (excluding overtime)}}{\textit{number of days worked during the same period}}$$

This minimum does not apply to partial weeks in which COP begins or ends.

— ***Casual or temporary employees***, or other intermittent employees who are not part of the regular work force and who do not work each week, receive weekly pay (including prorated amounts for partial weeks) as computed for part-time flexible employees.

When casual employees or other employees with specific terms of employment are injured, authorize COP only through the end of their appointments.

Example: If a casual employee is hired for 89 days and becomes injured on the 85th day, COP is covered only through the 89th day.

— **Transitional employees** are noncareer employees hired to fill positions normally held by career employees for a temporary period not to exceed 359 days. These employees work each week but may not work the same hours weekly. Transitional carriers are hired at the level and initial step of the position they are filling (i.e., Level 5 or Level 6) and receive COLA. All other transitionals (APWU) are hired at the level and initial step of the position they are filling but *do not* receive COLA.

If an employee is hired for 89 days and the appointment is changed to 60 days because of lack of work before the date that the injury occurred, COP is awarded through the 60th day.

13.3 Providing COP for Employees Being Terminated — *ICCO or designated control point personnel*

☐ Ensure that COP is not interrupted as part of a disciplinary action nor terminated as a result of a disciplinary action that terminates employment unless final written notice of termination for cause was issued to the employee before the date of injury.

— If an employee has received notice of a disciplinary action or termination prior to injury, provide COP only through the end of his or her appointment.

— If an employee receives notice of a disciplinary action or termination after the DOI, provide COP beyond the date of separation. The employee is identified by special coding on Form 50, *Notification of Personnel Action*. The entries on Form 50 should reflect the following:

– Item 21.....Code “9.”

– Item 22.....PP/YR 45th day of COP.

– Item 23.....Code “CP.”

– Item 95.....Code +“W.”

If, after separation, it is determined that COP is to be terminated before the date shown in item 22, completion of another Form 50 is required and must include the appropriate pay period and year in item 22.

☐ If a claim is submitted before termination of employment and if the separation date was identified before the DOI, COP is not provided beyond the day of separation. COP is not paid if any one of the following conditions applies:

— The disability is a result of an occupational disease or illness.

— The employee is neither a citizen nor a resident of the United States, Canada, or the territory under the administration of the Panama Canal Commission (i.e., a foreign national employed outside the areas indicated).

— The injury occurred off USPS premises, and the employee was not engaged in official “off-premises” duties.

— The injury occurred on USPS premises, but the employee was not engaged in any employment-related activity.

Example: The employee was injured when he or she came into work on his or her day off to pick up a paycheck or was changing a tire on a personal vehicle in the parking lot.

— The employee caused the injury by his or her willful misconduct, or intended to bring about his or her injury or death or that of another person, or the employee’s intoxication was the proximate cause of the injury.

— The injury was not reported on a form approved by OWCP (usually Form CA-1) within 30 days following the injury.

— Work stoppage first occurred more than 90 days following the injury.

— The employee initially reported the injury after employment was terminated.

◇ *COP may be paid if the medical evidence indicates that the claimant is fit for limited duty and limited duty is not provided. However, limited duty is not offered if the claimant has been terminated.*

□ For periods of disability either after the 45th day of COP or after the date of separation if COP was not authorized, instruct the claimant to request compensation payments by submitting a CA-7, *Claim for Compensation on Account of Traumatic Injury or Occupational Disease*, listing the dates of total disability and providing medical reports to substantiate such disability.

13.4 Recording COP for Most Full-Time, Part-Time, Transitional, Casual, or Temporary Employees — *ICCO personnel*

□ *On the DOI*, keep the injured employee in a work status or grant administrative leave for any fraction of a day or shift lost, so that the employee receives pay for the entire shift that he or she is scheduled to work. Do not charge the DOI to the 45-day COP period, except when the injury occurs before the beginning of the workday or shift.

— If an employee receives first-aid treatment and returns to work the same day, excuse his or her time spent for first-aid treatment to administrative leave. Do not require the employee to clock out when leaving the place of duty for first-aid examination or treatment.

— If an employee, including a casual or temporary employee, is directed by management to an on-site or off-site medical unit the same day as the accident, record the time spent waiting for and receiving medical attention as work time, up to all time that the employee would have been directed to work beyond the regularly scheduled shift.

◇ *An employee whose treatment extends beyond his or her scheduled end of shift is not to be credited with that time.*

— If an employee, except a casual or temporary employee, is excused from work during the scheduled shift, charge the remaining portion of the shift to Other Paid Leave (Administrative), rather than COP.

— If an employee is excused from work on a nonscheduled day for which the guarantee period applies, change the remaining portion of the employee's workday to Guaranteed Time and Guaranteed Overtime, as applicable.

Guaranteed Time

Guaranteed time, under the guarantee provisions of collective bargaining agreements, is time paid for but not worked because the employee has been released by the supervisor and has clocked out before the end of a guaranteed period.

Example: Most bargaining unit full-time regular employees are guaranteed 8 hours of work or pay if called in on their nonscheduled day to work. If such an employee works 6 hours and is then released, and told by his or her supervisor to clock out because of lack of work, the remaining 2 hours of the employee's 8-hour guarantee are recorded as guaranteed time.

□ *On any day or shift other than the DOI* when an employee stops work for a portion of a day or shift:

— If a *bargaining-unit or FLSA-nonexempt EAS employee* requires time off for treatment of an injury, count the day or shift as 1 full calendar day for the purpose of totaling COP, and record COP in any combination with workhours or any type of leave to equal a full service day:

- If work is available for the rest of the day and the employee is absent for all or any part of the remaining hours, record the absence as leave, LWOP, AWOL, etc., as appropriate, since absence beyond the time needed because of the injury cannot be charged to COP.
- If the employee is not allowed to work a partial shift, he or she is entitled to COP for the entire shift.

— If an *FLSA-exempt EAS employee* returns to work on a part-time basis because of medical limitations, or requires time off for treatment of the injury, COP is granted in full-day increments. Use of any COP counts as a full day toward the 45 days of COP regardless of FLSA status. Record COP only in combination with workhours, court leave, military leave, and administrative leave equal to a full service day of 8 hours.

- Do not combine COP with annual leave, sick leave, LWOP, or AWOL, which must be taken in 8-hour increments.
- If personal absence is granted for some or all of the balance of a full service day of 8 hours in which COP is taken, record the personal absence time as workhours.

13.5 Recording Limited Duty for Most Full-Time, Part-Time, Casual, Transitional, or Temporary Employees — *ICCO or designated control point personnel*

☐ When an injured employee is assigned limited duty, charge and record workhours to LDC 68, Operation 959.

SEE Chapter 7, Limited Duty Program Management.

13.6 Authorizing and Recording COP for Regular Rural Carriers — *ICCO or designated control point personnel*

□ Authorize COP on Form 1314, *Regular Rural Carrier Time Certificate,* by marking the Days Assigned Carrier Absent (DACA) block with code C for each day the carrier was scheduled to work. The code C will automatically pay other leave and also identify it as COP on generated reports. Rural carrier leave is charged in whole day increments only.

When the following day is a relief day, J or K day, or a holiday H, enter the appropriate relief or holiday code.

Record other paid leave, e.g., Administrative for the DOI, by marking the DACA block with a code O and annotating the back of the time card to read "Administrative leave due to on-the-job injury."

SEE Exhibit 13.6, Regular Rural Routes.

◇ *Pay procedures for rural carriers do not allow for two employees to be certified on the same route on the same day.*

13.7 Authorizing and Recording COP for Substitute Rural Carriers — *ICCO or designated control point personnel*

☐ For guidance in paying COP for substitute rural carriers, see 13.2, Authorizing COP for Most Full-Time, Part-Time, Transitional, Casual, or Temporary Employees.

☐ To determine the hourly pay rate for substitute carriers, find the quotient for their basic annual rate for a *40-hour evaluated route* at their specific *attained step* divided by 2,000. Add this amount to the quotient for the annual COLA rate divided by 2080. Level 5 RSC B is the same rate.

$$\textit{COP hourly rate} = \frac{\textit{Basic annual rate}}{2{,}000} + \frac{\textit{COLA}}{2{,}080}$$

Example: Basic annual rate for 40 hours at step 12:

($31,818) divided by 2,000		15.91
COLA ($1,997) divided by 2,080	=	+ .96
COP hourly rate		$16.87

13.8 Recording COP for Noncareer Temporary Relief Rural Carriers — *ICCO or designated control point personnel*

☐ To determine the hourly pay rate for temporary relief carriers, i.e., rural carrier associates and rural carrier reliefs, use the hourly salary.

13.9 Recording Limited Duty Hours for Regular Rural Carriers — *ICCO or designated control point personnel*

☐ When a regular rural carrier is working limited duty, record the hours by entering E in the DACA block of Form 1314, *Regular Rural Carrier Time Certificate,* for each day the employee is working on limited duty. This allows the regular carrier to be paid limited duty hours and COP leave hours that occur on the same day or days within a service week (see Exhibit 13.6, Regular Rural Routes).

☐ Determine the number of COP hours to be used in conjunction with limited duty hours by doing the following:

— Use whole COP hours in conjunction with limited duty hours to complete the week, remembering that COP cannot exceed 45 calendar days.

H or M route	=	6	days
J route	=	5.5	days
K route	=	5	days

— Ensure that limited duty hours plus COP hours do not exceed E days multiplied by the daily evaluated hours for J, H, and M routes. COP hours may be rounded to nearest whole number. For each day COP hours are recorded, the whole day counts toward completion of the 45-calendar-day allowance period. For K routes, ensure that limited duty hours plus COP hours do not exceed 40 hours in a week. Take 40 hours and deduct the limited duty hours to determine the COP hours.

☐ Record the number of hours in hundredths the employee works in the Limited Duty Hours block. Do not include these hours in the actual weekly workhours block.

☐ Pay limited duty hours at the evaluated hourly rate or level 5 attained step of RSC B, whichever is greater. Limited duty hours worked in excess of 40 are paid at 150 percent of the RSC B rate.

SEE Chapter 7, Limited Duty Program Management.

Leave and Compensation Administration

When leave or compensation is needed...

13.10 Authorizing Sick or Annual Leave During COP Period — *ICCO or designated control point personnel*

- ☐ Authorize only as much sick or annual leave as the employee has accrued and only for the 45-calendar-day COP period. The use of sick or annual leave does not extend the 45-calendar-day period. Pay that is attributable to the leave period is subject to taxes and other usual payroll deductions.
- ☐ If the employee subsequently requests COP instead of the previously requested annual or sick leave, the request must be made within 1 year of the date that leave is used or within 1 year of the date OWCP approves the claim, whichever is later.
- ◇ *The employee is not entitled to buy back that leave with later compensation payments.*

13.11 Adjusting Pay When OWCP Approves Controversion of COP — *ICCO or designated control point personnel*

☐ If OWCP finds that the employee is not entitled to COP after it has been paid, charge the payments to annual or sick leave (see Exhibit 13.11, Timekeeping Codes).

— Notify the employee, who then makes the choice between sick leave, annual leave, or both.

— Prepare a pay adjustment on Form 2240, *Pay, Leave, or Other Hours Adjustment Request*, and Form 2243, *PSDS Hours Adjustment Record*.

13.12 Recording Absences When Employee Receives Compensation for Wage Loss from OWCP — *ICCO or designated control point personnel*

☐ When an employee is absent from work while receiving compensation for wage loss from the OWCP, grant LWOP-IOD. Approve with Form 3971, *Request for or Notification of Absence,* hours type 49 or 25 in PSDS offices (see Exhibit 13.12, Leave Types).

13.13 Recording Absences When a Claim Is Pending — *ICCO or designated control point personnel*

- ☐ When there are no workhours while an OWCP claim is pending, record the employee's time either by regular LWOP hours (type 59, 60, or 23 in Postal Service Data Site (PSDS) offices), annual leave (55 or 01 in PSDS offices), or sick leave (56 or 02 in PSDS offices) as appropriate.
- ☐ If the claim is subsequently approved, process Form 2240, *Pay, Leave, or Other Hours Adjustment Request*, to change the leave type originally recorded to LWOP-IOD for the period of time that OWCP has approved payment.

13.14 Notifying Personnel of LWOP Status — *ICCO or designated control point personnel*

☐ When an employee has been in an LWOP status more than 30 days, notify the personnel services office to prepare Form 50 (see Exhibit 13.14a, Sample Letter: Personnel Notification — Leave Without Pay). The form will be submitted to the Minneapolis Information Systems Service Center (MNISSC) and annotated under item 50, Remarks, "LWOP for the purpose of receiving workers' compensation under PL93-416." The employee LDC should be changed to "67."

☐ When the employee returns to duty, notify the personnel services office via memo to update Form 50, item 50 to read "Return to duty" (see Exhibit 13.14b, Sample Letter: Personnel Notification — Return to Duty). The LDC must then be changed back to the appropriate LDC.

13.15 Recording Court Appearance Time When the USPS Prosecutes a Third Party Case — *ICCO or designated control point personnel*

☐ When an employee must appear in court as a witness in a third party action assigned to the USPS, place him or her in an official duty status for:

— Time spent in court.

— Time spent traveling between the court and his or her work site.

☐ Do not place the employee in an official duty status for: Time spent traveling between residence and the court because it is considered commuting time and, therefore, is not compensable.

13.16 Recording Court Appearance Time When an Employee Prosecutes a Third Party Case — *ICCO or designated control point personnel*

□ When an employee prosecutes a third party action in his or her own name, compensate the employee as follows:

— For court appearances:

– Compensate the employee as if he or she were in an official duty status by recording hours as work only, and not as court leave or any other type of leave, on the employee's time card. Form 3971, *Request for or Notification of Absence*, is not required.

– Have the employee document the time required for appearances on the memorandum, Third Party Court Appearance, (see Exhibit 13.16), and return it to the ICCO.

— For time used within the employee's work schedule to develop the case, charge time to annual leave or LWOP.

◇ *The employee is not in an official duty status as defined by the USPS, but the USPS makes this adjustment to implement the FECA provision requiring compensation of such an employee.*

Pay Adjustments and Recovery

When pay adjustments must be made...

13.17 Recovering Excessive COP Hours — *ICCO or designated control point personnel*

☐ Monitor COP hours to ensure that employees do not receive COP for more than 45 calendar days for any one injury. Use Report HRHO62, *Workers' Compensation — Injury on Duty,* for COP data. The report is produced each pay period by the MNISSC and printed automatically to each installation's system printer. It assists the ICCO and other postal officials in monitoring employees in a COP status.

COP in excess of the maximum number of hours could reflect:

— Overpayment.

— Two or more injuries.

— Inefficient authorization and tracking procedures.

☐ Recover excessive COP hours by initiating pay adjustment on Form 2243, *PSDS Hours Adjustment Record,* or Form 2240, *Pay, Leave, or Other Hours Adjustment Request*. Note whether the employee chooses sick, annual, and/or LWOP and send the form to the finance office. The finance office processes the form or sends it to the MNISSC if further processing is necessary.

13.18 Recovering Compensation Overpayment — *ICCO or designated control point personnel*

☐ Monitor compensation payments via PHC908P1, *Chargeback Summary Report,* and PHC931P1, *Chargeback Detail Report*. Immediately notify the OWCP district office of any overpayment.

When an overpayment is discovered, OWCP:

— Determines the period of absence from the job that resulted in the overpayment in the course of adjudication of the claim.

— Notifies the ICCO or point personnel and the employee of the period of disability that is approved by OWCP.

☐ Monitor action taken by OWCP on overpayments identified.

13.19 Processing Leave Buy Back — *ICCO or designated control point personnel*

Leave Buy Back

An employee who sustains a job-related disability may use sick or annual leave or both to avoid interruption of income. If the employee uses leave during a period of disability caused by an occupational disease or illness, and a claim for compensation is approved, the employee may, *with the approval of the USPS*, "buy back" the used leave and have it recredited to the employee's account.

If the employee uses leave during a period of disability caused by a traumatic injury and a claim is approved by the OWCP district office, the employee may buy back leave taken after the 45-day COP period. The employee may not repurchase leave taken during the 45-day COP period unless the employee was not entitled to receive COP. Computing the amount due the USPS to effect the leave repurchase is the responsibility of the USPS and is to be done in accordance with USPS accounting principles and practices.

If the USPS does not approve a repurchase of leave, then no compensation may be paid for the period leave was used. Where the USPS agrees to the leave repurchase, the employee may elect to have the compensation payable for the period paid directly to the USPS to be applied against the amount due the agency to effect the repurchase.

□ When an employee wishes to buy back leave used subsequent to the 45-day COP period, or leave used during a period of disability caused by an occupational disease or illness, advise the employee either orally or in writing of the USPS leave buy back policy (see Exhibit 13.19a, Sample Letter: Leave Buy Back Policy)

◇ *Leave cannot be repurchased during the COP period.*

□ Initiate a leave buy back request through completion and submission of CA-7 or CA-8. Such a form can request a buy back for those days or hours when medical certification of total disability is available or when leave was taken for related medical appointments or therapy. Proceed as follows:

— Determine the amount of leave used by the employee after the 45-day COP period.

— Determine if any of the annual leave being bought back is from a previous leave year. If so, determine whether this annual leave, when added to the annual leave carried over by the employee during that previous leave year, if any, will exceed the employee's annual leave carryover ceiling.

— If the amount of leave determined above exceeds the employee's annual leave carryover ceiling, take the following action:

  – Determine the amount of annual leave that can be bought back without creating a forfeiture situation.

- Inform the employee of the maximum amount of annual leave that can be bought back while remaining within the carryover ceiling.
- Caution the employee to buy back only the amount of annual leave that can be recredited and explain why.

☐ When OWCP has issued the form letter CA-1207 (see Exhibit 13.19b) with enclosure EN-1207, *Application for Reinstatement of Leave* (see Exhibit 13.19c), and the employee has completed items 1 and 2 and submitted the completed EN-1207 to the ICCO, complete items 3 through 7 and send the EN-1207 with a cover letter requesting the MNASC to process the leave buy back.

The MNASC makes pay adjustments changing paid leave to LWOP-IOD and sends Form 1903-DZ to the employee's work location showing deductions and net amount due from OWCP. A copy is sent to the employee.

☐ Send the verified CA-1207 to OWCP with the current amount of hours to be bought back.

☐ When OWCP submits approval on the CA-1207, advise the employee to complete and sign the back of the CA-1207, indicating that he or she will do one of the following:

— Pay the USPS directly and receive compensation from OWCP.

— Let OWCP pay compensation directly to the USPS MNISSC and he or she will pay or receive the difference.

◇ *The employee must authorize OWCP to pay the compensation to the disbursing officer, MNISSC, unless full pay for the leave period has previously been refunded.*

13.20 Initiating Health Benefits Refund — *ICCO or designated control point personnel*

Health Benefits Refund Enhancement to WCIS

Implementation of the automated processing of employee refunds of health benefit premiums became effective September 1995 (see Management Memo 95-24 dated 8-21-95).

☐ To ensure that an eligible employee receives his or her health benefit refund:

— Follow instructions provided in the WCIS *Health Benefits Guide* issued September 1995. Note: These instructions are also available on line by requesting them from the Health Benefits menu in WCIS.

— Maintain health benefits information for a period of 2 years before the initial implementation date (September 6, 1995) for processing of refunds. Information is available to the requester for the current quarter and one previous quarter beginning with postal quarter 4, FY 1995.

— Process manually all refunds covering periods earlier than postal quarter 4, FY 1995, by doing the following:

  – Retrieve Form 202, *Health Benefits Refund Payment Authorization*, from the WCIS.

  – In calculating the amount of the refund to be paid, subtract the difference between the OPM health benefits premium rate and the USPS rate of the health benefits plan chosen by the employee.

  – Obtain approval of the facility manager or designee.

  – Submit two copies of the refund authorization to the finance office for payment using Account Identifier Code 587, Fees for Service — Postal Operations.

  – File the original Form 202 in the employee's injury compensation file and one copy in the OPF.

The finance office will forward the refund and one copy of the Form 202 to the employee, and retain one copy for its records.

Recurrence of Disability

When the employee suffers a recurrence of disability...

SEE Chapter 5, Recurrence of Disability.

Exhibit 13.1

COP/LWOP-IOD Timekeeping Work Sheet

[ ] Traumatic **[ ] Illness/Disease** **[ ] Third party** **[ ] Controverted**

Employee:_____ SS#:_____ DOB:_____

Address:_____ Tele:_____ PL:_____

_____ DOI:_____ Nature of Injury:_____

OWCP No:_____ _____

Physician's Name, Address, Phone: _____ _____

Date Stopped Work:_____

_____

Date COP Began:

_____

Date Pay Stopped:

_____

AL/SL:_____

Date RTW:_____

RECURRENCES

Date: Date Stopped RTW WORK

DATE FORMS SENT TO OWCP

Forms	Date	Remarks

COP TRACKING SHEET

Day	Date	Comments	Day	Date	Comments	Compensation	
1			24				
2			25			*From*	*To*
3			26				
4			27				
5			28				
6			29				
7			30				
8			31			**Limited Duty**	
9			32				
10			33			*From*	*To*
11			34				
12			35				
13			36				
14			37				
15			38				
16			39				
17			40				
18			41			**Remarks:**	
19			42				
20			43				
21			44				
22			45				

Exhibit 13.6
Regular Rural Routes

Type Of Routes

H Route (Evaluated Hour Route)

The regular carrier's salary is based upon 12 days per pay period, 312 days per year, or 2,496 hours per year. Evaluated pay hours on an H type route may vary from 12 to 46 hours per week.

J Route (Evaluated Hour Route)

The regular carrier's salary is based upon 5 days during 1 week and 6 days the other week, for a total of 11 days per pay period, 286 days a year, or 2,288 hours per year. One relief day per pay period is authorized. Evaluated pay hours vary from 41 to 46 hours per week.

K Route (Evaluated Hour Route)

The regular carrier's salary is based upon 5 days each week, 260 days per year, or 2,080 hours per year. One relief day is authorized each week. The relief day must be the same day each week except for routes on rotating relief. Evaluated pay hours vary from 40 to 48 hours per week.

Rates of Pay

Basic Rate — the annual, daily, or hourly salary, excluding COLA.
Base Rate — the annual, daily, or hourly rate, including COLA.
Calculating Rate — base or basic daily and hourly rates determined by dividing the base or basic annual rate (BAR) as follows:

	Regular Center Carrier		Substitute Carrier	
Route Type	**Evaluated Daily Rate**	**Evaluated Hourly Rate**	**Evaluated Daily Rate**	**Evaluated Hourly Rate**
H or M (6-day workweek)	BAR ◇ 312	BAR ◇ 2496	BAR ◇ 302	BAR ◇ 2416
J (5½-day workweek)	BAR ◇ 286	BAR ◇ 2288	BAR ◇ 276	BAR ◇ 2208
K (5-day workweek)	BAR ◇ 260	BAR ◇ 2080	BAR ◇ 250	BAR ◇ 2000

Exhibit 13.11
Timekeeping Codes

Codes to be used with Distributed Data Entry or Distributed Reporting

43 Penalty Overtime
49 LWOP/IOD
52 Workhours
53 Overtime
54 Night Work
55 Annual Leave
56 Sick Leave
57 Holiday Work
58 Holiday Leave
59 Part Day LWOP
60 Full Day LWOP
61 Court Leave
62 Guarantee Time
65 Meeting Time
66 Convention Leave
67 Military Leave
68 Guarantee OT
69 Blood Donor
70 Stewards Time
71 COP
72 Sunday Premium
74 Christmas Work
76 Nonscheduled
86 Administrative Leave

Exhibit 13.12
Leave Types

Leave Types *(Information Only)*

Leave Type	Time Card Code	PSDS Code
LWOP-Lieu of Sick Leave	59/60	20
LWOP-Proffered	59/60	21
LWOP-Personal Reasons	59/60	22
LWOP-Part Day	59	23
LWOP-Full Day	60	23
LWOP-AWOL	59/60	24
LWOP-IOD-OWCP	49	25
LWOP-Maternity	59/60	26
LWOP-Suspension	59/60	27
LWOP-Union Official	84	28
LWOP-Suspension Pending Termination	59/60	29
Continuation of Pay (USPS)	71	03
Court Duty	61	04
Military Leave	67	05
Postmaster's Organization	89	08
Blood Donor Leave	69	09
Other Paid Leave	86	10
Convention Leave	66	12
Acts of God	78	13
Veteran's Funeral	79	14
Relocation	80	15
Civil Defense	77	16
Civil Disorder	81	17
Voting Leave	85	18

Exhibit 13.14a

Sample Letter: Personnel Notification — Leave Without Pay

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Leave Without Pay
To: Personnel Services Office
Re: ___[employee name]___
___[SSN]___
___[designation]___
___[P.O. and state]___

Effective ___[date]___, the above-named employee is to be placed in a leave without pay status for the purpose of receiving compensation because of an injury sustained while on the job. This employee is to remain in this status until ___[he/she]___ returns to work. The completed CA-7 was submitted to the OWCP district office on ___[date]___. The last day in pay status is ___[date]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Office

Exhibit 13.14b

Sample Letter: Personnel Notification — Return to Duty

[U.S. Postal Service Letterhead]

Date:
Our Ref:
Subject: Return to Duty
To: Personnel Services Office
Re: ___[employee name]___
___[SSN]___
___[designation]___
___[P.O. and state]___

On ___[date]___ you were informed that the above-named employee was placed in a leave without pay status for the purpose of receiving compensation because of an injury on the job from ___[date]___, until further notice. Leave without pay for this purpose terminated on ___[date]___. Your first date to return to duty status will be ___[date]___, ___[full time/part time]___.

Sincerely,

___[signature]___
___[name]___
___[title]___
Injury Compensation Office

Exhibit 13.16

Third Party Court Appearance

Subject: Third Party Court Appearance
To: Postmaster/Installation Head
Attn:

I, the undersigned, attest to the validity and accuracy of the clock times entered below.

I understand that these entries must represent only the time my presence was required in court and, if applicable, travel from and to work.

I also understand that the deliberate furnishing of false information may result in a fine of not more than $10,000 or imprisonment of not more than 5 years, or both (18 U.S.C. 1001).

Signature of Employee	Witness to Signature

EMPLOYEE NAME _____

PAY LOCATION _____ IMMEDIATE SUPERVISOR _____

	Relevant Times	Employee's Initials
Date of Appearance: _____		
Time Departed Work (if applicable)		
Time Arrived Court		
Time Departed Court		
Time of Return to Work (if applicable)		

Document additional appearances as follows:

cc: Employer
Timekeeper

	Relevant Times	Employee's Initials
Date of Appearance: _____		
Time Departed Work (if applicable)		
Time Arrived Court		
Time Departed Court		
Time Return to Work (if applicable)		

	Relevant Times	Employee's Initials
Date of Appearance: _____		
Time Departed Work (if applicable)		
Time Arrived Court		
Time Departed Court		
Time Return to Work (if applicable)		

	Relevant Times	Employee's Initials
Date of Appearance: _____		
Time Departed Work (if applicable)		
Time Arrived Court		
Time Departed Court		
Time Return to Work (if applicable)		

	Relevant Times	Employee's Initials
Date of Appearance: _____		
Time Departed Work (if applicable)		
Time Arrived Court		
Time Departed Court		
Time Return to Work (if applicable)		

See Privacy Act Statement on page 2.

Privacy Act Statement

The collection of this information is authorized by 39 U.S.C. 401, 1003, and 5 U.S.C. 8339. This information will be used to compensate you for court appearances in connection with a third party case. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits, or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants, or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge, or complaints examiner appointed by the Equal Employment Opportunity (EEO) Commission for investigation of a formal EEO complaint under 29 CFR 1613; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to state Employment Security Agencies to process unemployment compensation claims; to a federal or state agency providing parent locator service or to other authorized persons as defined by Public Law 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to the Office of Personnel Management (OPM), Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs, health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employee/annuitant data systems used to analyze federal retirement and insurance costs. Completion of this form is voluntary; however, if this information is not provided, you may not be compensated.

Exhibit 13.19a

Sample Letter: Leave Buy Back Policy

Verbal or Written Information Provided To Injured Employee

To __[name]__:

This refers to your job-related injury or illness of ___[date]___, and the annual or sick leave related thereto used during the period _____.

A claim for compensation [was/will] be submitted to the Office of Workers' Compensation Programs (OWCP) for the above leave period. The buy back cannot be initiated until the period of leave buy back is approved by OWCP with submission of EN-1207.

You may use your sick or annual leave and then buy back the leave to prevent any interruption in pay while your claim for compensation is being processed by OWCP.

If you go into an LWOP status, you will not receive a compensation check until your claim is approved by OWCP. If your claim is disapproved, you will not be allowed to buy back your leave. The following information is provided for you to determine whether or not you want to use the buy back process:

1. Your claim must be approved by OWCP *before* you submit CA-7 and the subsequent CA-8. After completing them, you *must* submit forms CA-7 and CA-8 to the USPS for time verification.
2. Unless you are disabled 14 days or more after the 45 days of COP is exhausted, there is a 3-day LWOP waiting period before compensation can be paid. If the 3-day period is applicable, you will not be paid compensation for 3 days and will be required to pay back the *full* amount of leave pay received for the 3 days when buying back leave.
3. You will be required to reimburse the USPS the difference in your net pay and the amount of compensation for the leave period before your leave is restored. OWCP will pay your compensation to PDC and you will be required to reimburse any difference in the *net* pay you received. The amount you will be required to refund will depend on your compensation rate (75 percent with dependent, 66 2/3 percent with no dependent) and the amount of tax deductions you take. Because no tax deductions are made on compensation, in some instances the net pay may be less than the compensation rate. In these instances, the USPS will refund the difference to you. If the leave you buy back is from the preceding calendar year, you must refund the difference between compensation and *gross* pay, since no tax credit can be allowed. After this amount is paid, it can be used as a deduction on an amended tax return. If you have any further questions, consult your tax advisor.
4. Processing the leave buy back request may take a considerable amount of time. For this reason you should consider:
    a. That if you are planning to leave the Postal Service, you must allow sufficient time to process your leave buy back and credit your leave before actual separation. Buy back cannot be processed after you have been separated from the USPS.
    b. Whether you plan to carry over the maximum hours of annual leave to the next calendar year. If so, any annual leave you buy back must be accomplished during this calendar

year; otherwise, you cannot be reimbursed annual leave which would exceed the maximum carryover. Check with personnel services to find out the maximum carryover allowed.

5. During the buy back process, the period you were on leave will be changed to LWOP-IOD. Since you do not earn leave while on LWOP, the sick and annual leave you earned while in a leave status will be deducted from your leave balance. For example, for every 80 hours bought back and changed to LWOP, both annual and sick leave are reduced by the amount earned in one pay period.
6. If you intend to buy back leave, the buy back must be initiated within 1 year following your return to duty or within 1 year of the date OWCP approves your claim, whichever is later. Moreover, only current employees (i.e., employees on the rolls of the USPS) may buy back leave. Therefore, if you are separated from the USPS for any reason, you cannot buy back leave after you are off the rolls.

Exhibit 13.19b

Sample Letter: Form Letter CA-1207

U.S. Department of Labor

Employment Standards Administration
U.S. Department of Labor
Office of Workers' Compensation Programs
PO Box 566
New York, NY 10014-0566
(212) 337-2075

File Number:_____

Date of Injury:_____

Employee:_____

Dear Mr./Ms._____

The condition we accepted under the above case file number entitles you to all compensation and medical benefits provided under the Federal Employees' Compensation Act. If you either enter a leave-without-pay status or "buy back" the leave which you use as a result of the injury, you may receive compensation.

Based on information presently available to the Office of Workers' Compensation Programs (OWCP), you are eligible for $ ___[amount]__ gross compensation, which covers the period from ___[date]___ for total hours leave.

To buy back leave used as a result of your injury:

1. You must refund to the USPS the amount of pay which you received for leave during the above-stated period. This amount will be shown in item 6 on EN-1207, enclosed.
2. Your agency must change your leave record from "leave with pay" to "leave without pay" for the period in question.

If you are unable to refund the entire amount of leave pay received, you may arrange with the USPS to pay the difference between the leave pay and the gross compensation due.

To receive compensation for all or part of the leave period named above, complete items 1 and 2 on the enclosed EN-1207. An accountable officer of the USPS ISSC should then complete items 3 through 7 and return the form to OWCP. If you wish OWCP to pay your compensation directly to the USPS, check item 2(b).

US POSTAL SERVICE
INJURY COMPENSATION

If you have not returned to work and you lose pay or will enter a leave-without-pay status in the future, you should file claim for compensation on CA-8, which can be obtained from the USPS or from OWCP.

Sincerely,

Claims Examiner

Enclosure: EN-1207

Exhibit 13.19c

Application for Reinstatement of Leave (EN-1207)

File:_____

Employee:_____

Items 1 and 2 to be completed by employee:

1. I request reinstatement of my leave for the period from_____ through _____. (If leave was intermittent or involved partial days, show the specific dates and hours for which compensation is claimed.)
2. Check either (a) or (b):
   a. ____ I have refunded or made arrangements to refund all leave pay received. Please forward compensation directly to me.
   b. ____ I have arranged with the U.S. Postal Service (USPS) to refund only the difference between leave pay and compensation. Compensation which is due me should be paid to the USPS.

Signed_____ Date_____

Items 3 through 7 to be completed by an accountable officer of the USPS (in the USPS, by appropriate Information Systems Service Center).

3. Name and address of the USPS.
4. Total amount employee owes agency prior to any refund.
5. If applicable, are health benefits (HB) and optional life insurance (OLI) deductions for the period of leave repurchase included in the amount to be refunded as shown in the above 6
   a. _____ Yes _____ No. If no, has credit for deductions been requested from OPM? _____ Yes _____ No.
   b. If the period(s) covered by the request for HB/OLI refund or credit is different than shown in item 3, show the specific period(s) in item 9.
6. Remarks.
7. The USPS agrees to allow the employee to buy back his or her leave. Leave records will be, or have been, changed from “Leave with Pay” to “Leave without Pay” for the period:

Signature of accountable officer: _____

Title: _____ Date:_____

Appendix A

Abbreviations and Acronyms

AIC	account identifier code
APWU	American Postal Workers Union
ASM	*Administrative Support Manual*
AWOL	absent without leave
BAR	basic annual rate
BMC	Bulk Mail Center
BPS	Bill Payment System (under WCIS)
CE	claims examiner
CFR	Code of Federal Regulations
COLA	cost-of-living allowance
COP	continuation of pay
CSA	civil service account
CSRS	Civil Service Retirement System
CSS	Customer Services and Sales
DACA	days assigned carrier absent
DOI	date of injury
DOL	Department of Labor
ECAB	Employees' Compensation Appeals Board
EEO	Equal Employment Opportunity
ELM	Employee and Labor Relations Manual
FCE	functional capacity evaluation
FECA	Federal Employees' Compensation Act
FECA PM	*Federal (FECA) Procedure Manual*
FEHB	Federal Employees Health Benefit
FERS	Federal Employees' Retirement System
FFD	fitness-for-duty examination

FLSA	Fair Labor Standards Act
FMLA	Family and Medical Leave Act
GSA	General Services Administration
HB	health benefits
HR	human resources
HRIS	Human Resources Information System
IC	injury compensation
ICAS	Injury Compensation Analysis Summary
ICCO	Injury Compensation Control Office
IME	independent medical examination
IOD	injured on duty
LDC	labor distribution code
LR	labor relations
LWEC	loss of wage-earning capacity
LWOP	leave without pay
LWOP/IOD	leave without pay/injured on duty
MBC	medical bill certification
MISSC	Minneapolis Information Systems Service Center
MMI	maximum medical improvement
MSPB	Merit Systems Protection Board
NALC	National Association of Letter Carriers
NFRC	National Files Retention Center
OHNA	occupational health nurse administrator
OLI	occupational life insurance
OMF	official medical folder
OPF	official personnel folder
OPM	Office of Personnel Management
OWCP	Office of Workers' Compensation Programs
OWCP PM	*Federal (OWCP) Procedure Manual*

P&D	Processing and Distribution
PN	no wage-earning-capacity status
PR	regular periodic roll status
PSDS	Postal Service data site
RC	rehabilitation counselor
RC-S	rehabilitation counselor-screener
RS	rehabilitation specialist
RTD	return to duty
RTW	return to work
SSA	Social Security Administration
SSN	Social Security Number
USPS	U.S. Postal Service
VA	Department of Veterans Affairs
VMF	vehicle maintenance facility
WC-IOD	Workers' Compensation-Injury on Duty
WCIRS	Workers' Compensation Information Reporting System
WCIS	Workers' Compensation Information System

Appendix B

Addresses

OWCP District Offices

Address	District
US DEPT OF LABOR OWCP ONE CONGRESS ST 11TH FLOOR BOSTON MA 02113 617-565-2137	DISTRICT OFFICE 1 BOSTON
US DEPT OF LABOR OWCP 201 VARICK ST ROOM 750 NEW YORK NY 10014 212-337-2075	DISTRICT OFFICE 2 NEW YORK
US DEPT OF LABOR OWCP GATEWAY BLDG ROOM 15200 3535 MARKET ST PHILADELPHIA PA 19104 215-596-1457	DISTRICT OFFICE 3 PHILADELPHIA
US DEPT OF LABOR, OWCP 214 N HOGAN ST, SUITE 1006 JACKSONVILLE FL 32202 904-232-2821	DISTRICT OFFICE 6 JACKSONVILLE

	For case numbers ending in 000–499...	*For case numbers ending in 500–000...*
Adjudication Branch	*Team (CAA)* SUITE 1001 ZIP CODE 32202-4222 904-232-1270	*Team (CBA)* SUITE 1002 ZIP CODE 32202-4223 904-232-1270
Post Adjudication Branch	*Team (CCA)* SUITE 1003 ZIP CODE 32202-4224 904-232-1274	*Team (CDA)* SUITE 1004 ZIP CODE 32202-4225 904-232-1274
QCM – Case Management Branch	*Team (CEA)* SUITE 1005 ZIP CODE 32202-4238 904-232-1279	*Team (CFA)* SUITE 1016 ZIP CODE 32202-4231 904-232-1279
Re-employment Branch	*Team (CGA)* ALL CASE NUMBERS SUITE 1007 ZIP CODE 32202-4232 904-232-4004	*Team (P90)* SUITE 1009 ZIP CODE 32202-4234 904-232-4008
PRMS Branch	*Team (P80)* SUITE 1008 ZIP CODE 32202-4233 904-232-4008	
Medical Bills/ Bill Management	SUITE 1011 ZIP CODE 32202-4237	

OWCP District Offices

Address	District
US DEPT OF LABOR OWCP 1240 E NINTH ST ROOM 851 CLEVELAND OH 44199 216-522-3800	DISTRICT OFFICE 9 CLEVELAND
US DEPT OF LABOR OWCP 230 S DEARBORN ST 8TH FLOOR CHICAGO IL 60604 312-353-5656	DISTRICT OFFICE 10 CHICAGO
US DEPT OF LABOR OWCP CITY CENTER SQUARE 1100 MAIN STREET KANSAS CITY MO 64105 816-426-2195	DISTRICT OFFICE 11 KANSAS CITY
US DEPT OF LABOR OWCP 1801 CALIFORNIA ST SUITE 915 DENVER CO 80202 303-391-6000	DISTRICT OFFICE 12 DENVER
US DEPT OF LABOR OWCP 71 STEVENSON ST SECOND FLOOR SAN FRANCISCO CA 94105 415-744-6610	DISTRICT OFFICE 13 SAN FRANCISCO
US DEPT OF LABOR OWCP 525 GRIFFIN ST ROOM 100 DALLAS TX 75202 214-767-4707	DISTRICT OFFICE 16 DALLAS
US DEPT OF LABOR OWCP 800 N CAPITOL ST NW ROOM 800 WASHINGTON DC 20211 202-565-8428	DISTRICT OFFICE 25 WASHINGTON, D.C.

OWCP District Office Lockbox Depository

Always provide OWCP case file number and claimant name on the check.

Address	District
US DEPARTMENT OF LABOR FECA PO BOX 371546M PITTSBURGH PA 15251	DISTRICT 1 BOSTON
US DEPARTMENT OF LABOR FECA PO BOX 360148M PITTSBURGH PA 15251	DISTRICT 2 NEW YORK
US DEPARTMENT OF LABOR FECA PO BOX 360304M PITTSBURGH PA 15251	DISTRICT 3 PHILADELPHIA
US DEPARTMENT OF LABOR FECA PO BOX 360418M PITTSBURGH PA 15251	DISTRICT 6 JACKSONVILLE
US DEPARTMENT OF LABOR FECA PO BOX 360762 PITTSBURGH PA 15251	DISTRICT 9 CLEVELAND
US DEPARTMENT OF LABOR FECA PO BOX 360525M PITTSBURGH PA 15251	DISTRICT 10 CHICAGO
US DEPARTMENT OF LABOR KANSAS CITY FECA OFFICE PO BOX 845038 DALLAS TX 75284-5038	DISTRICT 11 KANSAS CITY
US DEPARTMENT OF LABOR DENVER FECA OFFICE PO BOX 60000 FILE NUMBER 81251 SAN FRANCISCO CA 94160-1251	DISTRICT 12 DENVER
US DEPARTMENT OF LABOR SAN FRANCISCO FECA OFFICE PO BOX 60000 FILE NUMBER 21249 SAN FRANCISCO CA 94160-1249	DISTRICT 13 SAN FRANCISCO
US DEPARTMENT OF LABOR SEATTLE FECA OFFICE PO BOX 60000 FILE NUMBER 61252 SAN FRANCISCO CA 94160-1252	DISTRICT 14 SEATTLE
US DEPARTMENT OF LABOR DALLAS FECA OFFICE PO BOX 843537 DALLAS TX 75284-3537	DISTRICT 16 DALLAS

OWCP District Office Lockbox Depository

Always provide OWCP case file number and claimant name on the check.

Address	District
US DEPARTMENT OF LABOR FECA PO BOX 360392M PITTSBURGH PA 15251	DISTRICT 25 WASHINGTON DC
US DEPARTMENT OF LABOR PO BOX 371280M PITTSBURGH PA 15251	DISTRICT 50 NATIONAL OFFICE

Federal Records Centers

Address	District
MILITARY PERSONNEL RECORDS NATIONAL PERSONAL RECORDS CTR 9700 PAGE BLVD ST. LOUIS MO 63132-5100	Designated records of the Department of Defense
CIVILIAN PERSONNEL RECORDS NATIONAL PERSONNEL RECORDS CTR 111 WINNEBAGO ST ST. LOUIS MO 63118-4199	Entire Federal Government for personnel records of separated employees; pay records of all Federal employees; medical records of civilian employees of the Army, Navy, and Air Force; records of agencies in greater St. Louis, MO area
FEDERAL RECORDS CTR 380 TRAPELO RD WALTHAM MA 02154-6399	Maine, Vermont, New Hampshire, Massachusetts, Connecticut, and Rhode Island
FEDERAL RECORDS CTR MILITARY OCEAN TERMINAL BLDG 22 BAYONNE NJ 07002-5388	New York, New Jersey, Puerto Rico, and the Virgin Islands
FEDERAL RECORDS CENTER MILITARY OCEAN TERMINAL 500 WISSAHICKON AVE PHILADELPHIA PA 19144-4898	Delaware and Pennsylvania, east of Lancaster
WASHINGTON NATIONAL RECORDS CTR WASHINGTON DC 20409-0001	District of Columbia, Maryland, Virginia, and West Virginia
FEDERAL RECORDS CENTER 1557 ST. JOSEPH AVE EAST POINT GA 30344-2533	North Carolina, South Carolina, Tennessee, Mississippi, Alabama, Georgia, Florida, and Kentucky
FEDERAL RECORDS CENTER 7358 SOUTH PULASKI RD CHICAGO IL 60629-5898	Illinois, Wisconsin, and Minnesota
FEDERAL RECORDS CENTER 3150 SPRINGBORO RD DAYTON OH 45439-1883	Indiana, Michigan, and Ohio
FEDERAL RECORDS CENTER 2312 EAST BANNISTER RD KANSAS CITY MO 64131-3011	Kansas, Iowa, Nebraska, and Missouri except the greater St. Louis, MO area
FEDERAL RECORDS CENTER PO BOX 6216 FORT WORTH TX 76115-0216	Texas, Oklahoma, Arkansas, Louisiana, and New Mexico
FEDERAL RECORDS CENTER PO BOX 25307 DENVER CO 80225-0307	Colorado, Wyoming, Utah, Montana, North Dakota, and South Dakota

Federal Records Centers

Address	District
FEDERAL RECORDS CENTER 1000 COMMODORE DRIVE SAN BRUNO CA 94066-2350	Nevada (except Clark County), California (except Southern California) and American Samoa
FEDERAL RECORDS CENTER 24000 AVILA RD LAGUNA NIGUEL CA 92656-3497	Clark County, Nevada; Southern California (counties of: San Luis Obispo, Kern, San Bernadion, Santa Barbara, Ventura, Los Angeles, Riverside, Orange, Imperial, Inyo, and San Diego); and Arizona
FEDERAL RECORDS CENTER 6125 SAND POINT WAY NE SEATTLE WA 98115-7999	Washington, Oregon, Idaho, Alaska, Hawaii, and Pacific Ocean area (except American Samoa)

Appendix C

Definitions

assignment	A written agreement whereby the injured employee or beneficiary transfers his/her right to recover damages from a third party to the USPS and such offer is accepted by the USPS. (See Chapter 10.)
beneficiary	An individual who is entitled to certain benefits under the Act when the employee dies as a result of the job-related injury. (See Chapter 1.)
benefits	Any of the following: 1. Continuation of pay (COP) paid by USPS. (COP is not considered “compensation” by the OWCP.) 2. Money paid to claimants by the OWCP because of loss of wages or earning ability. 3. Money paid in the form of schedule awards (e.g., loss of finger). 4. Money paid as reimbursement for medical diagnostic and treatment services supplied under FECA. 5. Money paid to survivors of employees whose death is job-related. 6. Certain payments to individuals who are participating in an approved vocational rehabilitation program. (See Chapter 1.)
burden of proof	The claimant’s responsibility to provide evidence to substantiate the following five features of the claim: 1. The time. 2. The fact of USPS employment. 3. The fact of injury. 4. The fact of performance of duty. 5. The existence of causal relationship between job and injury. (See Chapter 8.)
challenge	The formal administrative procedure through which USPS management presents evidence to OWCP to dispute any element of an employee’s claim for benefits that appears questionable. (See Chapter 8.)
chargeback	The system of billing Postal Service Headquarters for payments related to OWCP-approved claims and then having them charged to the local USPS installation having jurisdiction over the employee at the time of the injury or illness. (See Chapter 12.)

claim	An assertion, in writing, of an individual's entitlement to benefits under FECA. This claim must be submitted on the required form. 1. A claim may be filed for a traumatic injury (Form CA-l), an occupational illness or disease (Form CA-2), or death (Form CA-5 or 5B). 2. A claim for injury may include reimbursement for the replacement or repair of medical braces, artificial limbs, and other prosthetic devices, and for such time lost while such devices or appliances are being replaced or repaired. However, a claim is not appropriate for the replacement or repair of eyeglasses and hearing aids unless the damage or destruction is a direct result of a personal job-related injury requiring medical services. (See Chapters 3 and 4.)
claimant	An individual whose claim for benefits and/or compensation has been filed in accordance with FECA.
claims examiner	An OWCP employee possessing special training and experience in claims adjudication.
compensation	See *benefits*. *Compensation* refers to all listed items except COP.
continuation of pay (COP)	A benefit a traumatically injured employee may request, i.e., continuation of his/her regular pay with no charge to sick leave or annual leave for the first 45 calendar days of disability. COP is subject to taxes and all other usual payroll deductions. The 45-day calendar period begins at the start of the employee's first full tour following the day of injury, or the first day following the disability, whichever occurs sooner. COP can be received only if the disability begins within 90 days of the occurrence of the injury. (See Chapter 4 and Chapter 13.)
contract medical provider	A duly licensed physician or medical facility under contract with the USPS and designated to perform specific medical duties. (See Chapters 2 and 6.)
control office	See *injury compensation control office*.
control point	An individual designated by an installation head (or functional manager in large installation). Control point personnel are trained to coordinate certain program activities with the control office. Their responsibilities include the authorization of medical treatment (i.e., issuance of Form CA-16, *Request for Examination and/or Treatment*) and to review medical documentation to determine the employee's duty status. (See Chapter 3.)
controversion	The formal administrative procedure through which USPS management presents evidence to OWCP to dispute an employee's claim for COP. (See Chapter 8.)

daily roll	A system used by OWCP for the payment of compensation payments when the term of disability is not likely to exceed 60 days, unless return to work is imminent. The employee must submit Forms CA-8 to support continued payment while on the daily roll system. (Refer to FECA PM 2-811.)
damages	The measure of the injury for purposes of third-party liability. The ICCO tries to recover compensatory damages (compensation for the injury). The two types of damages are: 1. Special damages (or "specials"), damages to which an exact dollar amount can be assigned, e.g., medical expenses. 2. General damages, those to which an exact dollar amount cannot be assigned, e.g., pain and suffering. (See Chapter 10.)
employee	Postal Service employee to whom FECA coverage extends, i.e., a full-time, part-time, or temporary (including casual and transitional) employee, regardless of length of time on the job or type of position. (See Chapter 8.)
Employee Assistance Program (EAP)	A USPS program designed to assist employees who have job performance or conduct problems due to personal or job-related issues. The EAP provides assessment, short-term counseling, referral, and case management services to help employees maintain productivity. If there is a strong suspicion or evidence that an employee's personal or job-related problem has directly or indirectly caused an injury, an EAP referral should be initiated. Referrals and subsequent participation must be in compliance with EAP established procedures.
Federal Employees' Compensation Act	Statutory provisions that are the source of entitlement to workers' compensation benefits for Federal workers as cited in Title 5, United States Code, 8101, as amended in l974. (See Chapter 1.)
fitness-for-duty examination (FFD)	A physical examination conducted by a physician for the USPS (i.e., contract medical provider) to determine the employee's current medical status. The results of the FFD are documented on Form 2485, *Medical Examination and Assessment*, which becomes part of the OWCP case file. A copy is also maintained in the employee's official medical folder. The purposes of a FFD are to evaluate medical status, to confirm or verify limited duty capabilities, and/or to assist in the rehabilitation effort. (See Chapter 6.)
first-aid injury	A work-related minor injury that requires no more than two medical visits, the second of which is to confirm full recovery. (See Chapters 3 and 4.)

health unit	A unit in a designated postal facility professionally staffed with one or more nurses who provide nursing services, first-aid treatment, and triage to injured employees. The health unit nurses are supervised by the occupational health nurse administrator (OHNA). (See Chapter 6.)
injury	Traumatic or occupational injury. Includes damage to or destruction of medical braces, artificial limbs, and other prosthetic devices. The term does not include damage or destruction of eyeglasses and hearing aids, unless the damage is a direct result of a personal job-related injury requiring medical services.
injury compensation control office	The office that administers and controls all aspects of the injury compensation program within the installation in which it is domiciled and/or its defined area of responsibility. (See Chapter 1.)
labor distribution code (LDC)	A payroll code number that identifies the major work assignment of the employee. The LDC's pertaining to Injury Compensation are: 1. LDC 68: LIMITED DUTY workhours of injured employee who is temporarily working in a modified assignment, either part- or full-time (see *limited duty*). LDC 68 should not be used when injured employee is performing: a. Core duties of regular assignment with minor modification or accommodation. b. Full duties of existing position other than his/her regular assignment. c. Same duties as those of regular position at another location. 2. LDC 69: REHABILITATION PROGRAM workhours of injured employee who is permanently working in a modified assignment, either part- or full-time (see Rehabilitation Program). LDC 69 should not be used when injured employee is permanently assigned to: a. Core duties of regular assignment with minor modification or accommodation. b. Another existing position for which he/she can perform core duties. c. Residual vacancy for which he/she can perform the core duties.
lien	A claim on the recovery of damages in order to satisfy a debt. (See Chapter 10.)

light duty	An assignment (temporary or permanent) of an employee partially disabled from a non-job-related injury or illness. Light duty assignments are subject to the "Light Duty" provisions of the applicable collective bargaining agreement and must be initiated by the employee in writing.
limited duty	A temporary assignment to accommodate a temporary partial disability as a result of a job-related injury (employee is expected to return to full duty or prognosis not yet determined; employee has not been declared permanently partially disabled). See *LDC 68* and *modified assignment*. (See Chapter 7.)
medical emergency	An injury or sudden and unexpected onset of a condition requiring immediate medical care. Some problems are emergencies because if not treated promptly they might become more serious (e.g., animal bites, eye injuries, deep cuts, broken bones). Others are emergencies because they are potentially life-threatening (e.g., heart attacks, strokes, weapon wounds, sudden inability to breathe). (See Chapter 3.)
modified assignment	A temporary or permanent assignment designed to accommodate the specific medical restrictions of an injured employee. Normally, individual tasks are identified and combined to develop a modified assignment. These tasks are usually subfunctions and may be from multiple positions. Assigned tasks must be fully consistent with the physical limitations specified by the appropriate medical authority. (See Chapters 7 and 11.)
monthly pay	The greatest of the following: 1. Monthly pay at time of injury, 2. Monthly pay at time disability begins. 3. Monthly pay at time compensable disability recurs if the recurrence begins more than 6 months after the injured employee resumes full-time employment with the USPS or other government agency.
negligence	Failure to act as an ordinary prudent person would act under the same or similar circumstances when such failure is the proximate cause of an injury. (See Chapter 10). Both third-party negligence and employee negligence are factors in third-party liability cases. Negligence may be: 1. *Comparative* greater or lessor wrongdoing of the third party or employee when their negligence is compared. The total recovery is reduced by the proportion of negligence by the employee. 2. *Contributory* contributing to the injury. In certain states, contributory negligence by the employee bars recovery of damages.

occupational illness/disease	An illness or disease produced by one of the following: 1. Systemic infections. 2. Continued or repeated stress or strain. 3. Exposure to toxins, poisons, fumes, etc. 4. Other continued and repeated exposure to conditions of the work environment over a longer period of time than a single day or work shift. (See Chapter 4.)
occupational health nurse administrator (OHNA)	A USPS or contract nurse responsible for the administration of the National Medical Program at the district level. This responsibility includes but is not limited to supervising on-site health units, providing assistance to Postal management in all medically-related matters, and oversight of all contracted medical providers. (See Chapter 6.)
Office of Workers' Compensation Programs	The Office of the Department of Labor (DOL) that has overall responsibility for the administration of the Federal Employees' Compensation Act (FECA). (See Chapter 1.)
periodic roll	A system utilized by OWCP whereby the U.S. Treasury pays prolonged disability cases each 28 days and death cases each month automatically until advised otherwise by OWCP. (Refer to FECA PM 2-811 and 2-812.)
physician	Any surgeon, podiatrist, dentist, clinical psychologist, optometrist, chiropractor, or osteopathic practitioner used within the scope of his or her practice as defined by state law. Exceptions are as follows: 1. Chiropractors, if their reimbursable services are other than treatment consisting of manual manipulation of the spine to correct subluxation as demonstrated to exist by X ray. 2. Naturopaths, faith healers, and other practitioners of the healing arts, as they are not recognized as physicians within the meaning of FECA. (See Chapter 3.)
prima facie medical evidence	Medical evidence that indicates the employee is disabled as a result of a job-related injury. This evidence does *not* need to include a specific diagnosis, a rationalized opinion concerning causal relationship, or specific reference to the circumstances of the injury. (See Chapters 3 and 4.)
prosecute	Any action taken to recover damages, as from a third party. (See Chapter 10.)
recurrence	The reappearance of the original symptoms or pains of a previously reported and accepted injury. The recurrence must not have been caused by a specific act or series of acts. (See Chapter 5.)

senior injury compensation specialist	The person who is responsible for organizing, managing and coordinating the Injury Compensation program within the boundaries of the district. This person supervises the control office staff, provides technical guidance and training to supervisors, and ensures proper program implementation. (See Chapter 1.)
serious injury	For purposes of third-party liability, a personal injury that results in death, dismemberment, significant disfigurement, a fracture, or permanent loss of use of a body organ, member, function, or system. (See Chapter 10.)
short term roll	A system utilized by OWCP whereby payment of disability compensation is made for a specified, relatively near-term period when the medical matrix or medical reports indicate full recovery within several months. The short term roll is also applicable when there is a question regarding the severity and duration of disability, or a deficiency in the medical reports. (Refer to FECA PM 2-811.)
subrogation	The acquisition by one person of the rights of another person to bring a claim. This can occur only if the person making payment is legally obligated to do so. Technically, the USPS is not subrogated to an injured employee's rights against the third party. Rather, it has a lien against any recovery that is made. (See Chapter 10.)
survivor	See *beneficiary*.
third-party liability	Those instances in which an injury or illness suffered by an employee is caused by a person or organization not in the employ of the USPS or any branch of the federal government. (See Chapter 10.)
tort	A wrongful act committed intentionally or negligently that causes injury. Third-party tort claims involve such acts resulting in injury to an employee. (See Chapter 10.)
traumatic injury	A wound or other condition of the body caused by external force, including stress or strain. The injury: 1. Must be identifiable as to time and place of occurrence and member or function of the body affected. 2. Must be caused by a specific event or incident or series of events or incidents within a single day or work shift. 3. May also include damage to or destruction of prosthetic devices or appliances. (See Chapter 4.)

Appendix D
Forms

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OWCP Form CA-1 Instructions

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

Summary

Purpose

Official notice to the employee's supervisor and to the OWCP that a traumatic injury has been sustained (or it is alleged to have been sustained).

General Procedures and Preparation Responsibilities

a. The employee, or the employee's representative, desiring to report an injury or claim benefits under the FECA, is provided a CA-1 by his or her supervisor.

b. The employee or the representative completes items 1–15 and submits the form to his or her supervisor.

   Note: When emergency medical care is required, the form may be completed after medical care has been provided.

c. The supervisor, after reviewing the employee's portion of the form for accuracy and completeness, completes and returns the attached receipt to the employee. At this time, the supervisor should advise the employee if the claim will be controverted; if there is doubt, the employee should be advised that a decision to controvert will be made after an investigation is made.

d. The supervisor completes the supervisor's portion of the form. The control office or point completes items 23–26.

e. The supervisor prepares Form 1769, *Accident Report.*

f. The supervisor submits the completed form and witness statement(s), if available, and a copy of the Form 1769, to either the control office or the control point.

Timeliness

The employee is required to submit the claim within 2 working days following the injury. Statutory time requirements are met if filed within 3 years. To be eligible for COP, the claim must be filed within 30 calendar days following the day of injury. OWCP requires that the completed CA-1 be submitted to the office within 10 working days following receipt of the claim from the employee.

Instructions

Providing the Form

When an employee desires to report a traumatic injury, and the description of how the injury took place fits an on-the-job traumatic injury, the CA-1 will be provided to the employee for his or her completion. When the employee is not physically or mentally capable of completing the form, the employee's representative completes it. A supervisor may complete the form for the employee only if it is absolutely necessary.

When the CA-1 is issued, the supervisor should provide instructions as to what is required. Basically, the employee should be advised that Items 1–15 *must* be completed with detailed entries. The employee *must* be advised that either block *a* or block *b* of Item 15 must be selected — even if no immediate disability is indicated. The employee must also be advised of the right to elect either continuation of pay or sick or annual leave in the event that disability is realized as follows:

a. An injured employee may have the option to elect sick or annual leave for the period of disability. Pay that is attributable to the period of such leave is subject to taxes and all other usual payroll deductions. Leave is limited to the amount that has been earned. An employee who elects to take sick or annual leave during the 45-day period in which continuation of pay is available, is not entitled to buy back that leave with compensation payments he or she later receives. However, if an employee elects to use sick or annual leave during a period of disability and later decides that the use of COP is desired, COP will be paid retroactively, if requested within 1 year.

b. An injured employee may have the option to elect continuation of pay for the first 45 calendar days of disability. Such pay is subject to taxes and all other appropriate payroll deductions.

When the completed CA-1 is submitted to the supervisor by the employee, or by the employee's representative, the supervisor must review the form for accuracy, detail, and completeness. Corrections should be made by the employee or representative, if necessary. All changes should be initialed by the employee or representative.

Note: The date in Item 11 must be the date the completed CA-1 was submitted to the supervisor or another responsible USPS management representative.

The *Receipt of Notice of Injury* is required to be presented to the employee or the representative at the time the form is submitted to management. Such receipt is the evidence an employee needs to prove not only that a claim was submitted in the event that the original documents are lost, but also to show the timeliness of the claim's submission.

When the receipt is completed, it is to be completed in its entirety. At this time the employee or the representative should be advised that the receipt should be retained in a safe place to ensure that it is available in the future.

Filing and Distribution

a. If the claim is not reported to the OWCP:

(1) File the original of CA-1 in the employee's OMF; use a sealed envelope if no OMF is available.

(2) Place a copy in the IC claim file notated "Original in OMF."

(3) Send a copy to the safety office, after deleting any sensitive medical information.

b. If the claim is reported to the OWCP:

(1) Forward an original copy of CA-1 to the district OWCP by either a USPS injury compensation control office or the office or installation designated to correspond with the OWCP.

(2) Send a copy to the IC claim file.

(3) Send a copy to the safety office.

First Aid Injuries

When either the initial medical visit or one-time follow-up medical care is provided to confirm full recovery following the day of injury during the employee's regularly scheduled workhours, the claim must be reported to the OWCP. This applies to medical care provided either on or off postal premises and includes treatment by both postal medical units and contract physicians. First aid injuries will be discussed in greater detail later on in this course.

Note: If the CA-1 is complete and other materials, such as medical reports and witness statements are not available, or if a controversion package is contemplated, the CA-1 should be dispatched to the OWCP with Item 38 annotated accordingly, or with a cover letter explaining the situation.

Employee's Portion of the Form, Items 1–15

Item 1 through 15 will be completed by either the injured employee or by his or her representative.

Exceptions: The shaded blocks, a, b, and c will be completed by either the IC Control Office or control point.

The following instructions should be followed when completing the employee's portion of the form; Items not listed are self-explanatory.

Item Explanation

6. Insert appropriate designation, i.e., PS/10; EAS/16/8, etc.

8. If "Other" in Item 8 is checked, have employee submit related information, e.g., identity and relationship. If no dependents, enter "None."

Check appropriate box(es). If *other* is checked, have employee submit related information on an attachment; e.g., identify children aged 18 through 22 who are either full-time students or who are unable to care for themselves, identify dependent parents, brothers, sister, grandparents or grandchildren. Please note that married children cannot be claimed as dependents even when residing with the parent. Also, if child support is paid for children living elsewhere due to a divorce or separation, a copy of the court order is to be attached.

9. *Exact* location where injury occurred. If off postal premises, identify the street address, location on property or street, etc. If on postal premises, identify the building and/or room, location, work area, column, grid, parking lot location, stairwell, etc.
10. Month, day, year *and* time of injury. If injury developed over a period of time during a single tour, enter the time period.
11. Date of notice is the day on which the claim form is submitted.
12. The title requested is the formal title of the employee's position within the Postal Service. This Item will be used to identify the code to be inserted into shaded block *a*. Claimant's title and either FTR, PTF, PTR, Casual, TE, EAS, PCES, or other category.
13. Description of *how* and *why* the injury was sustained. If the space is insufficient, use continuation sheet.
14. Identification of the part of the body injured and type of injury such as a bruised right heel, strained lower back, etc. It is important that the employee identify all parts of the body injured to preclude later misinterpretation.
15. The claimant must check either block *a* or *b* even if there is no expected time loss. Prior to making a selection, the claimant must be advised of the COP benefit versus taking personal leave. This selection must be an informed selection. Check for signature and understanding of penalty statement.
16. Witness names and statements are obtained by the supervisor. If only one witness, have him or her complete; if insufficient space, use an attachment.

    If multiple witnesses, list names in Item 16 with notation to see attachments. If no witnesses, have claimant enter such and initial.

    Note: Supervisor should obtain witness statement ASAP.

Official Supervisor's Portion of the Form, Items 17–38

Items 17 through 38 will be completed by the immediate supervisor of the injured employee or by the Injury Compensation Control Office or Control Point.

Item Explanation

17. Per instructions on the form and the USPS policy, this is the identification and address of the *control office authorized* to communicate with the district

OWCP. This is the office authorized to receive correspondence from the OWCP. *This is not always the installation in which the injured employee is employed.* See Item 18.

Note: The OSHA Site Code block is not required at this time.

18. Enter the name and full address of the installation in which the injured employee is employed. This could be an associate office, a branch, a station, a repair facility, a VMF, etc.

19. a. If claimant has fixed duty hours, enter start and end times.

    b. If claimant has variable or flexible hours, enter "Variable" following "Regular Work Hours."

20. a. If the claimant has a fixed workday schedule, check the scheduled workdays.

    b. If claimant has a rotating (carrier), or flexible schedule or a variable workday schedule, enter either "Variable" or "Rotating" and enter "Week of Injury" then check the days worked during the week of injury.

21. Enter the date of injury. If this item does not agree with item 10, enter reason in item 34 or on an attachment.

22. This is the date that the claim form was received either by the immediate supervisor *or by a management representative*. This item is significant to determine eligibility for COP, e.g., was the claim form submitted within 30 days after the injury.

    In the event that the supervisor submits the CA-1 to the control office or point on the day of the injury before medical reports are received to determine the duty status of the claimant, Items 23–26 should be completed by the control office.

23. This item refers to the first tour of duty or date on which the injured employee either did not report to work, or stopped work, following the day of injury, due to disability caused by the traumatic injury:

    a. Enter "Did Not Stop" if employee continued on duty.

    b. Enter "Did Not Stop" if employee missed work only to obtain medical care or therapy — no disability certified.

    The time entry will be either the start time of the first tour of duty missed, *following the day of injury*, or the actual time the employee departed the work area or installation, *following the day of injury, due to disability, not just for medical care or therapy.*

24. Enter a date only if the claimant enters a leave without pay (LWOP) status following the day of injury.

25. a. If there is neither no period of certified disability for which COP is paid, nor absences from scheduled duty hours for medical care or therapy for which COP is paid, enter "NA."

b. If disability is certified immediately following the injury, the 45-day period of COP can be either: (1) the day following the day of injury even if it is an unscheduled day or a holiday (all holidays that fall within a period of COP will be counted as a day of COP, but holiday pay will be given), or (2) if the injury was realized during an overtime preceding the scheduled tour of duty, and if certification of disability verified that the employee could not report to the next scheduled tour, then the date could be the day of injury.

c. If the CA-1 was submitted more than 30 days after the day of injury, enter "Not Eligible."

26. If the employee did not stop work (i.e., no disability), enter "Did Not Stop Work." Remember that this item must agree with Item 23. If disability has been realized, and the employee has not returned to duty before submission of the CA-1 to the OWCP, enter "Has Not Returned."

27. Was the claimant on the clock, on the assigned route, involved in horseplay, etc. If the supervisor cannot make a definite judgment, enter "Undetermined."

28. If it is possible to definitively answer this Item either *Yes* or *No*, do so. However, if there is any possibility that a *Yes* answer could not be supported upon investigation, enter "Undetermined."

29–30. a. If there is clear evidence that a third party was not responsible for the injury, check "No."

b. If there is clear evidence that a third party was responsible for the injury, check "Yes." Identify the third party and have employee complete a Form 2562, *Notice of Potential Third Party Claim*. Assist the employee if necessary.

c. If it is unclear if a third party was responsible, enter "Undetermined." A third party is an individual or organization (other than the injured employee or the federal government) who is liable for the illness or disease.

31. This Item is to be completed with information related to the first physician who first provided medical care to the injured employee.

Note: If initial care was given by a nurse or other health professional (not a physician), indicate this on a separate attachment. The attachment should include at least the name, position, date of treatment, diagnosis, and address of the health professional. Note that a physician's assistant is not a physician under the Act. Reports from physician's assistant may be accepted only if countersigned by a physician.

If initial treatment was provided by a health unit nurse or contract physician enter word "Agency."

32. This is the date of the first visit to the physician listed in Item 31.

33. Refer to either a CA-17, acceptable medical reports, or other reliable sources, i.e., conversation with the treating physician, or personal knowledge relative to the seriousness of the injury.

34. a. If information is available (first hand, not hearsay) that contradicts the claimant's information, check the *No* block and submit the documentation either in Item 34 or on an attachment. Indicate whether attachment is provided.

    b. If a determination cannot be made pending the completion of an investigation, enter "Decision Pending Investigation."

    c. If there is no contradictory information, check the *Yes* block.

35. If there is clear evidence that either the total claim or COP should be controverted, state the reason of the controversion in detail in the space provided. Advise the employee of your intent to controvert and the justification of the controversion action.

36. Enter claimant's annual or hourly base pay rate. If normal schedule includes night time differential or Sunday premium, such compensation should be included. Leave blank if Item 23 is blank or insert "Did Not Stop."

37. Supervisors should be aware of the penalty warning contained in this Item and enter commercial telephone number.

    a. Printed name and signature of the supervisor completing this form.

    Note: The supervisor completing the form should be the claimant's immediate supervisor, on the day of injury or on the day notice is given.

    Enter date form was completed.

    b. Title and commercial phone number of supervisor completing the form.

38. Check appropriate box. If uncertain, control office will enter.

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

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 and step at date of injury Level Step
7. Employee's home mailing address (Include City, State, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Child 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.
11. Time ☐ a.m. ☐ p.m.
12. Date of this notice Mo. Day Yr.
13. Employee's occupation
14. Cause of injury (Describe what happened and why)
15. 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

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 I was not caused by my willful misconduct, intent to injure myself or another person, or 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 its official representative). This authorization also permits any official or 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 criminal prosecution as well as to any 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 _____

Form CA-1
Rev. Sept. 1993

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) ZIP Code

19. Regular work hours: From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

20. Regular work schedule: ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

21. Date of injury: Mo. Day Yr.

22. Date notice received: Mo. Day Yr.

23. Date stopped work: Mo Day Yr Time: ☐ a.m. ☐ p.m.

24. Date Day stopped: Mo. Day Yr.

25. Date 45 day period began: Mo Day Yr

26. Date returned to work: Mo Day Yr Time: ☐ a.m. ☐ p.m.

27. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No" explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

29. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to Item 31.)

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

31. Name and address of physician who provided medical care (Include city, state, ZIP code)

32. First date medical care rendered: Mo Day Yr.

33. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

35. If the employing agency controverts continuation of pay, state the reason in detail:

36. Pay rate when employee stopped work: $ Per

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly participates in any false statement, misrepresentation, concealment of fact, etc., in regard 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 exceptions:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Official phone

38. 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

Form CA-1
Rev. Sept. 1983

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 benefits for job-related 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. However, to avoid potential interruption of pay, the form should be filed within 3 working days. If the form is not filed within 30 days, compensation may be disallowed for continuation of pay.)

(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such 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 retained disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services when necessary.

(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care, however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic job-related injury, he or she may request substitution of pay or use of sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, this pay must not be immediately charged until:

(1) The employing agency receives medical information from the attending physician as the extent that disability has terminated;

(2) The OWCP advises that pay should be terminated; or

(3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid overpayment of income, the form should be filed on the 40th day of the COP period. Form CA-1 may be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

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 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish a requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (6) Disclosure of a social security number (SSN) is voluntary. The failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you, from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury submitted by
(Name of injured employee)

_____

Which occurred on (Mo., Day, Yr.)

_____

at (Location)

_____

Signature of Official Supervisor | Title | Date (Mo., Day, Yr.)

_____

Form CA-1
Rev. Nov. 1989

Instructions for Completing Form CA-1

Complete all items in 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 employee's behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give specific and complete facts (i.e., 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 appropriate (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 file CA-1 within thirty days of the injury, you are 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. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you change your election within one year, the agency is obliged to compensate pay periods of leave for COP, which qualify.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either charge COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the report of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 18 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 the 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 usually works.

28) 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 the injury. If initial care was given by a nurse or other health professional (nurse practitioner) in the employing agency's health unit or clinic, indicate that 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) Does the employing agency controvert continuation of pay?

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 results from an occupational disease or illness;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the police force of a former President;

c) The employee is neither a citizen of 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 30 days or more following the injury;

h) The employee initially rejected 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.

U.S. GPO: 1991-282-137/80069 Form CA-1
Rev. Nov. 1988

OWCP Form CA-2 Instructions

Notice of Occupational Disease and Claim for Compensation

Summary

Purpose

Official notice to the employee's supervisor and to the OWCP of a condition believed by the employee to have been caused, aggravated, or accelerated by factors of his or her work environment.

General Procedures and Preparation Responsibilities

a. The employee, or the employee's representative, desiring to report an illness or disease is provided a CA-2 by the employee's supervisor. At this time, the supervisor will review the employee's instructions for completing Form CA-2 that are attached to the CA-2. He or she will ensure that the employee or the representative is aware of the data requirements and the need for a narrative statement from the employee.

   Note: The employee will also be provided two or more copies of the appropriate evidence checklist, OWCP Form CA-35 — one for each physician and one for the employee.

b. After completing the form and preparing the statement, the employee will submit the form and statement to the supervisor or the designated agency official. At this time, the employee may submit the required medical data or have made arrangements for such to be submitted.

c. The supervisor, after ensuring that the form is complete, gives the employee or the representative the receipt attached to the CA-2.

d. The supervisor completes the superior's portion of the form, leaving blank those Items for which he or she does not have information.

e. The supervisor prepares a statement commenting on the accuracy of details in the statement submitted by or on behalf of the employee.

f. The supervisor prepares Form 1769, *Accident Report*.

g. The supervisor submits the CA-2, the employee's and the supervisor's statement, medical reports if received, and a copy of the Form 1769 to the IC control office or control point.

Timeliness

a. The employee or the representative should submit the claim within 30 days after realizing that the disease or illness was caused, aggravated, or accelerated by the employment.

b. The control office must forward the CA-2 and supporting documentation to the OWCP within 10 working days after receipt from the employee. If the

employee did not submit the required statement and medical data, he or she should be apprised of the fact that failure to comply with the instructions could jeopardize the acceptance of the claim. If the CA-2 is submitted without the supporting data, submit the form to the OWCP with a memo stating that the employee was apprised of the need to submit the additional data, but has failed to do so.

c. When notified by the OWCP that the claim has been either accepted or rejected, the control office must notify the safety office to initiate appropriate action relative to the Form 1769.

Filing and Distribution

a. If the claim *is not* reported to the OWCP do the following:

(1) File the original Form CA-2 in the employee's OMF; use a sealed envelope if no OMF is available.

(2) Send a copy to the IC claim file notated: "Original in OPF."

(3) Send a copy to the safety office, after deleting any sensitive medical information.

b. If the claim *is* reported to the OWCP:

(1) Forward the original CA-2 to the district OWCP by either the IC control office or by the office or installation designated to correspond with the OWCP.

(2) Place a copy in the IC claim file.

(3) Send a copy to the safety office, after deleting any sensitive medical information.

Instructions

Forms Completion

Employee's Portion of the Form, Items 1–18.

Items 1 through 18 will be completed either by the claimant (employee) or by his or her representative.

Exceptions: The shaded blocks *a, b,* and *c* will be completed by the IC control office.

The following instructions should be followed when completing the employee's portion of the form. *Items not listed are self-explanatory.*

Item: Explanation

6. a. Insert appropriate designation, i.e., PS-5/9, EAS-16/18, EAS-20, PCES, etc.

b. Considering the location identified in Items 10 and 13, refer to item 29 for the date the claimant was last exposed to the conditions alleged to have caused the disease or illness, i.e., date employee last worked, etc. If the claimant is still working in the area of exposure, give current grade information.

8. If "other," in item is checked, have employee submit related information, e.g., identify dependent parents, brothers, sisters, grandparents, or grandchildren who are dependent on the employee.

   Check appropriate box(es). If *other* is checked, have employee submit related information on an attachment; e.g., identify children aged 18 through 22 who are either full-time students or who are unable to care for themselves, identify dependent parents, brothers, sister, grandparents or grandchildren. Please note that married children cannot be claimed as dependents even when residing with the parent. Also, if child support is paid for children living elsewhere due to a divorce or separation, a copy of the court order is to be attached.

9. The title requested is the formal title of the employee's position within the Postal Service. This Item will be used by the HRS to identify the code to be inserted into shaded block *a*.

10. Exact location where the claimant alleges he or she was exposed to conditions causing the illness or disease. Be sure that the location identified can be located by his or her immediate supervisor.

11. The date the employee first *became aware* of the illness or disease; this date may or may not agree with Item 12.

13. The employee should identify the specific conditions, substances, activities, etc., which he or she believes are responsible for the illness or disease.

14. Be sure that the specificity required on the instruction page of the form is provided, e.g., right, left, inside thigh, etc.

16. Do not leave blank. Enter "NA" if employee's statement has been received or submitted.

17. Do not leave blank. Enter "NA" if medical documentation has been received or submitted.

18. a. The employee or the representative should be aware of the certification statement in this Item and the penalty notice which follows.

    b. The date should be *the date the form is submitted* to either the supervisor or a management representative.

Official Supervisor's Portion of the Form, Items 19–34.

Items 19 through 34 will be completed either by the immediate supervisor or by the control office.

The following instructions should be followed when completing the supervisor's portion of the form; Items not listed are self-explanatory.

Note: Explanation

19. Per instructions on the form and USPS policy, this is the identification and address of the control office authorized to communicate with the district OWCP, this is the office authorized to receive correspondence from the OWCP. *This is not always the installation in which the injured employee is employed. See Item 20.*

    a. The OWCP Agency Code will be entered by injury compensation control personnel.

    b. The OSHA Site Code is not required.

20. Enter the name and full address of the installation in which the injured employee is employed. This could be an associate office, a branch, a station, a repair facility, a VMF, etc.

21. a. If claimant has fixed duty hours, enter start and end times.

    b. If claimant has variable or flexible hours, enter "Variable," DOI (Date of Injury) *hours listed*, and then enter work schedule for DOI.

22. a. If claimant has a fixed schedule, check the scheduled days.

    b. If claimant has either a rotating (carrier) or flexible schedule, or a variable workday schedule, enter either "Variable" or "Rotating" and enter *week of injury;* check the days worked during the week of the injury.

23. This item is completed with information related to the *first physician* who provided medical care for the disease or illness (see 5 U.S.C 8101 (2) for definition of a physician).

    Note: *If initial care was given by a nurse or other health professional (not a physician), indicate this on a separate attachment.* The attachment should include the name, position, date of treatment, diagnosis, and address of the health professional. Physician's assistants reports *must* be countersigned by a *physician* to be acceptable.

24. This date is the date of the first visit to the physician listed in Item 23.

25. Consider only medical reports form countersigned by *physicians*.

27. a. This Item refers to the first tour of duty or date on which the injured employee either did not report to work, or stopped work, due to disability caused by illness or disease identified in Item 14.

    b. The time entry is either the start time of the first tour of duty missed, or the actual time the employee departed the work area or installation due to disability.

    c. If claimant is not disabled, enter "Did Not Stop Work."

28. A date is entered *only* if the employee enters into a leave without pay (LWOP) status caused by absence due to the illness or disease.
29. Identify the date the employee was last exposed to the conditions alleged to have caused or aggravated the disease or illness. This could be the last day on the job before a transfer to another location, the last day on the job before period of disability, etc.
30. If the employee did not stop work, i.e., no disability, enter "Did Not Stop Work." Remember that this Item must agree with Item 27.
31. If the employee has been assigned to either light or limited duty because of medically prescribed limitations, attach a copy of the written job description for such duty.
32. A third party is an individual or organization (other than the injured employee or the federal government) who is liable for the illness or disease.
34. Supervisors should be apprised of the penalty warning contained in this Item, and they should enter their commercial telephone number.

The *Receipt of Notice of Injury* is required to be presented to the employee or the representative at the time the form is submitted to management. Such receipt is the evidence an employee needs to prove not only that a claim was submitted in the event that the original documents are lost, but also to show the timeliness of the claim's submission. When the form is completed, it must be completed in its entirely. At this time, the employee or the representative should be advised that the receipt should be retained in a safe place to ensure that it is available in the future.

Occupational Disease — Checklists

CA-35A, *Evidence Required in Support of a Claim for Occupational Disease*

CA-35B, *Evidence Required in Support of a Claim for Work-Related Hearing Loss*

CA-35C, *Evidence Required in Support of a Claim for Asbestos-Related Illness*

CA-35D, *Evidence Required in Support of a Claim for Work-Related Coronary/Vascular Condition*

CA-35E, *Evidence Required in Support of a Claim for Work-Related Skin Disease*

CA-35F, *Evidence Required in Support of a Claim for Work-Related Pulmonary Illness (not asbestosis)*

CA-35G, *Evidence Required in Support of a Claim for Work-Related Psychiatric Illness*

CA-35H, *Evidence Required in Support of a Claim for Work-Related Carpal Tunnel Syndrome*

Notice of Occupational Disease
and Claim for Compensation

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

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
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., Da., Yr.)

4. Sex

5. Home telephone (Include Area Code)

6. Grade and step of last position held

Level

Step

7. Employee's name, mailing address (Include city, state, and ZIP code)

8. Date is:
- Wife, Husband
- Child under 18 years
- Other

Claim Information

9. Employer's address

9a. Occupation code

10. Location (address) where you worked when disease or illness occurred (Include city, state, and ZIP code)

11. Date you last worked because of disease or illness
Mo. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment
Mo. Day Yr.

13. Explain the relationship of your employment and why you came to this realization

14. Nature of disease or illness

CWCP Use - Job Data

b. Type code

c. Status code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above at item 12, explain the reason for the delay

16. If the statement requested at item 9 of the attached instructions is not furnished with this form, explain reason for delay.

17. If the medical report requested in item 9 of attached instructions is not furnished with this form, explain reason for delay

Employee Signature

I hereby, under penalty of law, state the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my use of alcohol or drugs. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

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 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

Have your supervisor complete the remainder of 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 to criminal prosecution and may, under appropriate criminal statutes, be punished by a fine or imprisonment or both.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402

Form CA-2
Rev. Sept. 1995

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

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and ZIP Code)

OWCP Agency Code

OSHA Site Code

ZIP Code

20. Employee's City, State (Street address and ZIP Code)

ZIP Code

21. Regular work hours: From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

22. Regular work schedule: ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician providing medical care (include city, state, and ZIP code)

24. First date medical care received: Mo. Day Yr.

25. Employee reports above employee is disabled due to work: ☐ Yes ☐ No

26. Date employer first recorded condition to supervisor: Mo. Day Yr.

27. Date and hour employee stopped work: Mo. Day Yr. Time ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped: Mo. Day Yr. Time ☐ a.m. ☐ p.m.

29. Date employee was (a) exposed to condition(s) alleged to have caused disease or illness: Mo. Day Yr.

30. Date returned to work: Mo. Day Yr. Time ☐ a.m. ☐ p.m.

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

32. Was injury caused by 3rd party? ☐ Yes ☐ No (If "No" go to item 34)

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

Signature of Supervisor

34. A supervisor who knowingly conceals or falsifies a statement, misrepresentation, concealment of fact, etc., in response to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and 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

Form CA-5
Rev. Sept. 1993

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 of 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 sustained 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.

If an employee has questions 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 I) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 et seq.), is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for duties, services, and computer matching to benefit and payment files.)

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 Supervisor) (Title) (Date (Mo., Day, Yr.))

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

Form CA-2
Rev. Sept. 1980

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. 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 10 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 prepared by the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the employee's standpoint.

b) Complete copies 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 physical 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) A description of the part of the body affected. (If disability is due to a mental condition, give complete details of all activities or other events which the employee feels to be causes or aggravations of the illness. 24 hours will suffice.)

e) A statement as to whether the employee ever suffered a similar condition. Also provide full details of prior history, and medical care received, along with names and addresses of physicians providing 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 address 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 18 through 34, the supervisor is responsible for filling in the proper codes in blocks 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. On a separate narrative statement attached to the form, the supervisor must:

a) Describe or detail the work performed by the employee. Identify fumes, chemicals, or other materials or situations that the employee was exposed to which allegedly caused the condition. State the nature, duration, and intensity of the exposure, including hours per day and days per week, represented above.

b) Attach copies of all medical reports (and diagnostic reports and laboratory data) in his or her personnel file.

c) Attach a record of the employee's absence from work caused by any number of 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. (If no co-workers have such knowledge, state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement and report.

The supervisor should submit any other information he or she deems pertinent to the merits of the claim.

Item Explanations. 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 location of any objective symptoms (e.g., rash on leg, carpal tunnel syndrome in 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 (usually OSH). The address of the personnel or compensation office.)

20. Employee's duty station, street address and ZIP code
The street address and zip code of the actual station where the employee actually works.

28. Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for the injury. If first care was given by a nurse or other health professional (e.g., physician's assistant), 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 28.

32. 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 adequate 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 Publication 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit to five digit numeric 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.

Form CA-2
Rev. Sept. 1993

OWCP Form CA-2a Instructions

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation

Summary

Purpose

When an employee sustaining an occupational injury or disease suffers disability for work due to the original injury, and such disability occurs after the employee returned to work following the injury, and the disability is the result of (1) a spontaneous return of the symptoms of the previous injury or disease without intervening cause, or (2) the need for medical treatment, other than a usual office call, for residuals of the previous condition. In these instances Form CA-2a is required. If a new incident or injury occurs which precipitates the disability, even if the injury is to the same part of the body previously injured, or is new exposure to the same causes(s) of a previously suffered occupational disease, this constitutes a new injury and Form CA-1 or CA-2 should be filed accordingly.

General Procedures and Preparation Responsibilities

a. When an employee desires to report or claim a recurrence, a Form CA-2a will be provided to him or her, with the instruction sheet.

b. The supervisor or HRS will discuss the circumstances of the situation and consider the definition of a recurrence on the instruction sheet with the employee to determine if either a recurrence or a new injury or illness exists. If a new injury (traumatic or occupational) was realized, either a CA-1 or CA-2 should be initiated.

c. When a recurrence is identified, the *employee* should read the *Instructions for Employee* on the opposite page and complete Items 1–23 on the form.

d. Upon receipt of the completed employee's portion of the form, along with any attachments or statements, the supervisor or control office or point will complete Items 24–44.

Filing and Distribution

The Injury Compensation Office does the following:

a. Forwards the original of the CA-2a, and any attachments, medical reports, etc., to the OWCP upon completion.

b. Places a copy in the IC claim file.

c. Sends a copy to Safety if there is lost time or workday.

Instructions

Part A, Items 1–23, is completed by the employee or his or her representative.

1. Claimant's complete name: last name, first name, and middle name; enter NMN if no middle name.
2. SSN consists of *nine* digits.
3. The OWCP file number from the original traumatic (CA-1) or occupational (CA-2) claim. Verify that the date in Item 11, below, agrees with the original claim date.
4. Date of birth, *not* today's date.
5. Self-explanatory
6. Claimant's home telephone number with area code; if none, enter "None."
7. Claimant's complete home address to include ZIP+4.
8. Check appropriate box(es). If *other* is checked, have employee submit related information on an attachment. e.g., identify children aged 18 through 22 who are either full-time students or who are unable to care for themselves, identify dependent parents, brothers, sister, grandparents or grandchildren. Please note that married children cannot be claimed as dependents even when residing with the parent. Also, if child support is paid for children living elsewhere due to a divorce or separation, a copy of the court order is to be attached.
9. Address of employing establishment at time of *original* injury or disease. Entry should agree with either Item 18 of the original CA-1, or Item 20 of the original CA-2.
10. Complete address of employing establishment at the time of the recurrence, if different from Item 9.
11. Date and time of original injury or disease; refer to either Item 10 on the CA-1, or Item 29 on the CA-2.
12. Month, day, year, and time the employee first realized he or she had sustained a recurrence, i.e., when symptoms first became apparent, when new medical care required, etc.
13. Month, day, year, and time the employee stopped work because of the recurrence.

    If he or she did not lose time, enter "Did Not Stop." If employee is absent from work only to obtain medical care or therapy, this is not considered stopping work; however, the claim must be submitted to the OWCP.
14. Month, day, year, and time the employee entered a non-pay LWOP status after stopping work. If the employee does not stop work or remains in a paid leave status; sick, annual, or COP; enter "NA."
15. This Item should complement Item 13.

a. If claimant did not stop work, enter “NA.” Item entry should agree with Item 13.

b. If claimant lost time from work and has returned, enter the date and the time the employee returned to work.

c. If claimant lost time from work and has not returned to work, enter “Has Not Returned.”

16. If claimant has obtained medical care for the recurrence prior to completing the form, all dates of treatments and therapy should be listed. Use an attachment if necessary.

17. If employee has obtained medical care following the recurrence, list the source(s) of such care. If CA-16 was issued, identify physician listed in Item 1 of the CA-16.

18. This Item refers to the original injury or disease.

    a. Following the original injury or disease, if the claimant either continued or returned to his or her original duties without disability limitations, check “Not.”

    b. Following the original injury or disease, if the claimant was permanently or temporarily unable to return to his or her normal duties, check “Yes.” Describe the medically prescribed disability or limitations and describe the physical requirements of the limited or rehab duties assigned.

19. The employee is to provide a detailed description of his or her condition since returning to work following the *original* injury and a description of *all* medical care received following his or her return to work following the original injury.

20. Instructions for this Item are clear; be sure the employee provides necessary and detailed information. Be sure the information provided supports a recurrence and does not support the need for a new claim, e.g., a CA-1 or a CA-2.

21. The employee is *required* to describe *all* injuries and illnesses suffered between the date he or she returned to work following the original injury and the date of the recurrence; and, submit all medical records relevant to the injuries.

22. Self-explanatory.

23. Date the CA-2a was submitted by the employee.

Part B, Items 24–44, will be completed by the supervisor or the Human Resources Specialist.

24. This is the identification and address for the injury compensation control office or point authorized to communicate with the district OWCP. *This is not always the installation in which the employee is employed*. See item 25.

25. Enter the name and full address of the installation in which the employee is *currently* employed. This could be an AO, a branch, a station, a repair facility, a VMF, etc. Entry should agree with Item 10.

26. Enter the date the employee was returned to his or her *regular* duties following the *original* injury or illness.

27. a. If claimant has fixed duty hours, enter start and end times.

    b. If claimant has variable or flexible hours, enter "variable, DOI hours listed," and then enter scheduled work hours on day of injury (DOI).

28. a. If the claimant has a fixed workday schedule, check the scheduled days.

    b. If claimant has either a rotating (carrier) or a flexible schedule, or a variable workday schedule, enter either *rotating* or *variable* and enter *week of injury,* then check the days scheduled for the week of injury.

29. Date of original injury or illness; refer to either Item 10 of the original CA-1, or Item 29 of the original CA-2. Compare to Item 11 entry by the claimant.

30. Date of recurrence, compare to Item 12.

31. Date stopped work following the recurrence, compare to Item 13.

32. Date employee entered a non-pay LWOP status following the recurrence, compare to Item 14.

33. If disabled following the recurrence and COP was paid, enter the period of such.

    If claim is being submitted before the employee returns to duty, enter "Has Not Returned."

34. a. Date the employee returned to work following the recurrence, compare to Item 15.

    b. If employee did not stop work, enter "Did Not Stop," compare to Items 14 and 31.

35. If employee used *personal* leave during period of disability — Items 31 and 34 — list dates by type of leave used.

36. a. Enter annual/weekly/hourly base pay (includes COLA if career employee).

       Control office or point will compute, as applicable, regularly scheduled night differential and Sunday premium pay and enter in Item 36d. If employee is entitled to territorial COLA, enter dollar amount per annum/week/hourly in block 36c and identify.

    b. If pay rate changed between the date of recurrence and the date of the work stoppage following the recurrence, enter the new pay data.

    Note: When an employee works less than his or her full tour between 6:00 p.m. and 6:00 a.m., provide pay information at either the weekly or annual rate to show the *total* night differential earned for the period.

37. When an employee is provided treatment by either the PMO or a USPS contract doctor, copies of all medical data is to be provided to the OWCP.
38. Self-explanatory.
39. When either a limited duty or a rehabilitation assignment was provided following the *original* injury or illness, enclose a copy of the limited duty/rehabilitation job offer/assignment.
40. When information available to management differs from the information provided by the employee, identify and support such differences.

41– 44. Self-explanatory.

Part C of the form is completed by the claimant if he or she is no longer employed by either the USPS or another federal agency at the time of the recurrence.

In such a situation, the claimant sends the form directly to OWCP. In this situation, the former employer may not be aware of the claim unless is it accepted by the OWCP and new payments appear on the chargeback report. If or when such charges to the USPS do appear, the injury compensation personnel should acquire from OWCP current medicals to ascertain if rehabilitation is in order.

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation Pay/Compensation

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

OMB No. 1215-0174
Expires: 07-31-95

Employee: Please Complete Part A below.

Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

Employee Data: Part A - Employee

1. Name of employee (Last, First, Middle)
2. Social Security number
3. OWCP File number for original injury (If known)
4. Date of birth (mo., day, yr.)
5. Sex: ☐ Male ☐ Female
6. Home telephone ( )
7. Employee's home mailing address (Include city, state, and zip code)
8. Dependents: ☐ Wife/Husband ☐ Children under 18 years ☐ Other
9. Name and Address of Employing Establishment at time of original injury (Number, Street, City, State, zip code)
10. Name and address of Employing Establishment at time of recurrence, if other than 9. If you are no longer employed with the Federal Government, complete Part C in addition to Part A.
11. Date and Hour of original injury (mo., day, year): ☐ a.m. ☐ p.m.
12. Date and hour of recurrence (mo., day, year): ☐ a.m. ☐ p.m.
13. Date and hour stopped work following recurrence (mo., day, year): ☐ a.m. ☐ p.m.
14. Date and hour pay stopped following recurrence (mo., day, year): ☐ a.m. ☐ p.m.
15. Date and hour returned to work (mo., day, year): ☐ a.m. ☐ p.m.
16. Dates of medical treatment following recurrence (mo., day, year)
17. Name and address of physician treating employee following recurrence
18. Are returning to work following the original injury, were you hand capped, or in any way limited in performing your usual duties? (If yes, explain) ☐ Yes ☐ No
19. Describe fully your condition since you returned to work including all medical treatment received
20. Describe the circumstances of the recurrence of disability. Explain why you believe your present condition is related to the original injury.
21. Describe all injuries and illnesses which you suffered between the date you returned to work following the original injury, and the date of recurrence. Arrange for the submission of all relevant medical 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.

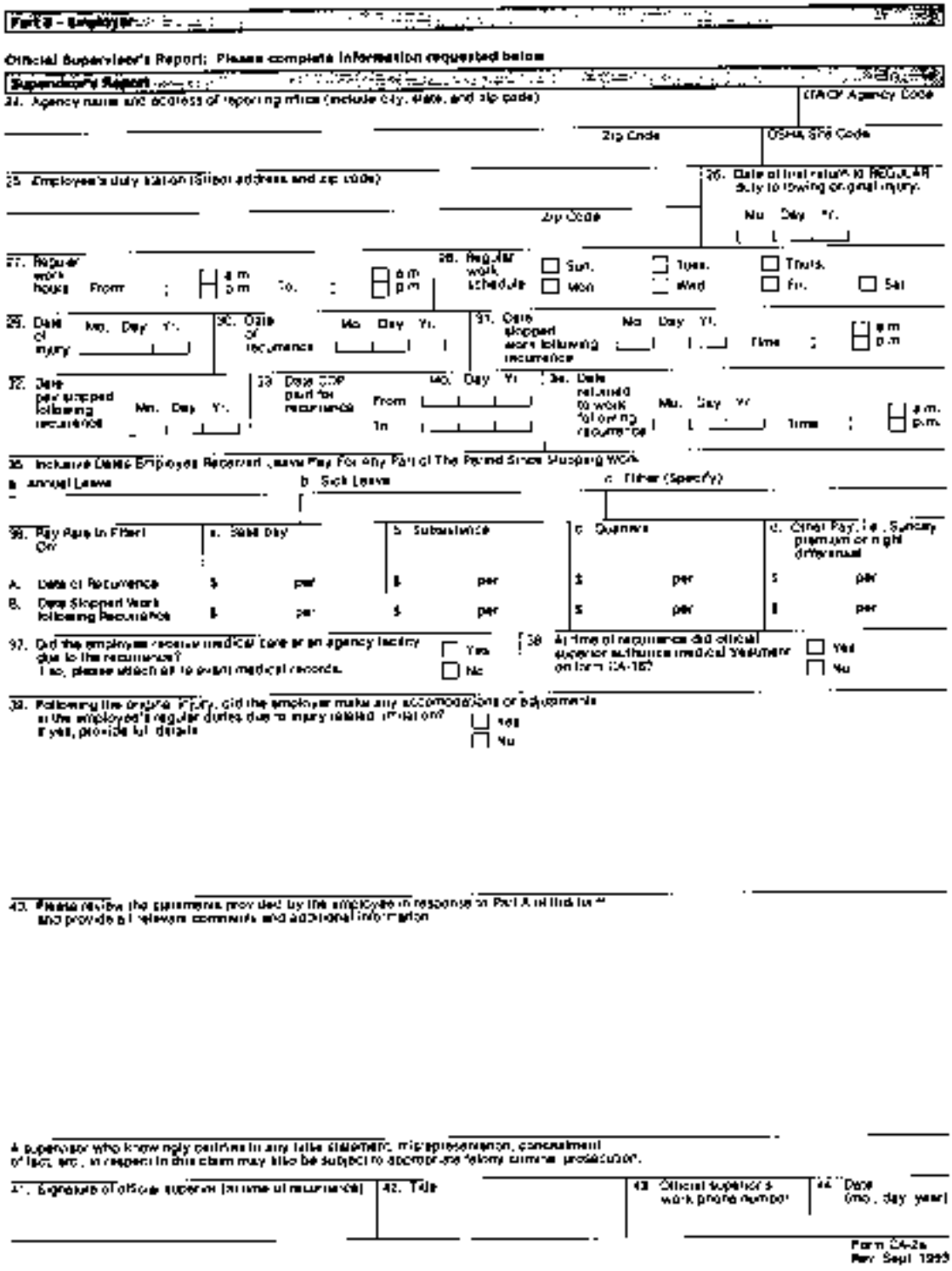
I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay and/or Compensation while disabled for work.

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 representatives). 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.

22. Signature of employee
23. Date (mo., day, year)

Form CA-2b
Rev. Sept. 1993



Part B - Employer

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

24. Agency name and address of reporting office (include city, state, and zip code) | (FACS) Agency Code | Zip Code | OSHA, SFS Code

25. Employee's duty station (Street address and zip code) | Zip Code

26. Date of first return to REGULAR duty following original injury: Mo. Day Yr.

27. Regular work hours From : a.m. p.m. To. : a.m. p.m.

28. Regular work schedule: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

29. Date of injury: Mo. Day Yr.

30. Date of recurrence: Mo. Day Yr.

31. Date stopped work following recurrence: Mo. Day Yr. Time : a.m. p.m.

32. Date employee stopped following recurrence: Mo. Day Yr.

33. Date COP paid for recurrence: From Mo. Day Yr. To

34. Date returned to work following recurrence: Mo. Day Yr. Time : a.m. p.m.

35. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave b. Sick Leave c. Other (Specify)

36. Pay Rate In Effect On:	a. Base Pay	b. Supervisor	c. Overtime	d. Other Pay, i.e., Sunday premium or night differential
A. Date of Recurrence	$ per	$ per	$ per	$ per
B. Date Stopped Work following Recurrence	$ per	$ per	$ per	$ per

37. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all to even medical records. Yes No

38. At time of recurrence did official supervisor authorize medical treatment on form CA-16? Yes No

39. Following the original injury, did the employer make any accommodations or adjustments in the employee's regular duties due to injury related limitation? If yes, provide full details Yes No

40. Please review the statements provided by the employee in response to Part A of this form and provide all relevant comments and additional information

A supervisor who knowingly performs in any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to stronger-than-felony criminal prosecution.

41. Signature of official supervisor (at time of recurrence) | 42. Title | 43. Official supervisor's work phone number | 44. Date (mo., day, year)

Form CA-2a
Rev. Sept. 1993

Part D—Employee
(To be completed by the employee if not employed with the Federal Government at the time of a claimed recurrence of disability attributed to an occupational injury or illness sustained while Federally employed.)

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

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

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

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

   $ _____ per _____

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

   If yes, for what period _____ through _____.

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

   If yes, how much and from what source? _____

Section 8101, et seq., Title 5 of the U.S. Code authorizes collection of this information. Completion of this form is mandatory in order to ensure 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 assess 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 needed medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; employee 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. Claimant Signature _____ 8. Date _____

U.S. GPO: 1993-341-193/53838

INSTRUCTIONS FOR COMPLETING FORM CA-2a
RECURRENCE OF DISABILITY

DEFINITION OF RECURRENCE

Recurrence - when an employee who sustained an occupational injury or disease suffers disability for work due to the original injury, and such disability occurs after the employee returned to work following the injury, and the disability is the result of (1) a spontaneous return of the symptoms of the previous injury or disease without intervening cause, or (2) the need for medical treatment, other than a casual office call, for residuals of the previous condition. In these instances Form CA-2a is required. If a new incident or injury occurs which precipitates the disability, even if the injury is to the same part of the body previously injured, or is new exposure to the same cause(s) of a previously suffered occupational disease, this constitutes a new injury and Form CA-1 or CA-2 should be filed accordingly.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of recurrence provided above. If you have suffered a recurrence, you should complete Part A completely. Attach a separate sheet of paper where necessary to provide full details.
- If you are employed by the Federal Government at the time of recurrence, Form CA-2a should be submitted promptly to your employing agency. If you are no longer employed with the Federal Government, you should complete Parts A and C and submit all materials directly to OWCP.
- If the original injury was not previously reported to OWCP, a report specifically covering the original injury should be made on Form CA-1 (traumatic injury) or CA-2 (occupational disease) and attached when Form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.
- If this is a recurrence of an occupational disease or if the 45 days Continuation of Pay (COP) have been exhausted, you may claim wage loss on Form CA-7. If this form was not submitted following original injury. If Form CA-7 was previously submitted, compensation may be claimed on Form CA-8. The OWCP will be responsible for payment of compensation if the claim is approved.
- You should arrange for the submission of a detailed medical report from your attending physician. The report should include: dates of examination and treatment; history given by the employee; findings, results of x-ray and lab tests; diagnosis; course of treatment; and the physician's opinion, with medical reasons, regarding causal relationship between your condition and the original injury. The physician should also describe your ability to perform your regular duties. If you are disabled for your regular work, he/she should identify the dates of disability and provide work tolerance limitations.
- If you were treated by other physicians after returning to work following the original injury, similar medical reports should be obtained from each.

INSTRUCTIONS FOR THE EMPLOYING AGENCY

- Upon receipt of a claim for recurrence, the employing agency should promptly complete Part B and submit it to OWCP.
- While pay is continued, the employing agency should obtain medical evidence on Form CA-17, "Duty Status Report", as often as circumstances indicate.
- If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Report of Termination of Disability and/or Payment, should be forwarded when the employee returns to work.
- If the recurrence happens less than six months following employee's return to work following the injury, the supervisor shall authorize required medical care by use of Form CA-16. If the recurrence happens more than six months after the employee's return to work, authorization for further medical care must be obtained from the OWCP.
- If the recurrent disability continues after the expiration of the 45 days Continuation of Pay (COP) or if this is a recurrence of an occupational disease, you should instruct the employee to file Form CA-7. If Form CA-7 was previously submitted, compensation should be claimed on Form CA-8.

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 of this collection of information, including suggestions for reducing this burden, send them to the Office of Ifrm Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, DC 20210, and to the Office of Management and Budget, Paperwork Reduction Project (1215-0167), Washington, DC 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

OWCP Form CA-3 Instructions

Report of Termination of Disability and/or Payment

Summary

Purpose

The purpose of this form is to notify the OWCP of the following:

a. Disability from injury or illness has terminated.

b. Continuation of pay (COP) has terminated.

c. The employee has returned to duty.

Note: CA-3 need not be completed if the above information has been previously submitted on Form CA-1, CA-2, or otherwise. However, some OWCP District Offices still request a CA-3 whenever either *a, b,* or *c* above is reported.

General Procedures and Preparation Responsibilities

a. Upon notification or receipt of information that the employee satisfied either *a, b,* or *c*, under Purpose the ICCO will initiate the CA-3.

b. If the employee has been on the OWCP periodic roll, the ICCO should immediately telephone the OWCP advising the date the employee returned to work or overcame the disability. This will preclude an overpayment.

Filing and Distribution

For filing and distributing, do the following:

a. Send the original CA-3 to the OWCP.

b. File a copy of the CA-3 in the claimant's injury compensation file.

Instructions

1. Claimant's complete name: last name, first name, and middle name (enter "NMN" if no middle name).
2. SSN consists of *nine* digits.
3. The OWCP file number from original traumatic (CA-1) or occupational (CA-2) claim. Verify that date in Item 7, below, agrees with original claim date.
4. U. S. Postal Service
5. Address of employing establishment at time of original injury or disease.
6. Address of control office authorized to forward to or communicate with the OWCP.

7. Date and hour of original injury or disease as shown on the CA-1 (Item 10) or CA-2 (Item 29).
8. a. If disability caused by a traumatic injury, refer to Item 25 on the original CA-1.
   b. If disability resulted due to an occupational condition, refer to Item 27 on the original CA-2.
   c. If disability resulted after a recurrence, refer to Item 10 on the related CA-2a.
9. Month, day, year, *and time* employee entered a non-pay LWOP status; see instructions for Item 8 in event disability and LWOP commenced upon filing a claim or recurrence.
10. Date employee returned to duty; or, if total disability has ceased and COP terminated, enter date and explain in Item 17, below, and enter "Has Not Returned" if appropriate.
11. a. If employee has not returned to work, enter "NA."
    b. If employee returns to his or her normal workweek, see either Item 20 on the CA-1, Item 22 on the CA-2, or Item 28 on the CA-2a.
    c. If employee returns to a workweek other than his or her normal workweek, so indicate.
12. Enter annual or hourly pay data if rate changed since date disability began; otherwise, enter "NA."
13. If, during the period of disability, the employee used either sick or annual leave, enter specific dates; indicate holiday or administrative leave used in Item 13c.
14. a. Check *No* if employee returns to normal duties.
    b. Check *Yes* if upon return to duty the employee's duties have been modified, or if the employee was given limited duty. Describe new or modified duties.
15. If the employee was not in a non-pay LWOP status at least one full pay period, enter "NA." If the employee was in a non-pay status at least one full pay period, enter the last day of the pay period from that health benefits or life insurance premiums were deducted.

    Note: See ELM 525 for procedures if employee's health or life insurance was not deducted and the OWCP did not assume payments.
16. Verify entry with HRIS/OPF if during an open season.
17. Enter any comments. Include reason for stopping COP, if employee refused work, etc. Attach supporting documentation. Also, if employee is on periodic roll, notify OWCP by phone — *immediately*.

Continuation of Pay: Complete this section only if COP was paid during the period of disability identified as beginning in Item 8, above, and the day prior to the date in Item 10, above, unless information was previously submitted on a CA-7.

18. If COP was paid during the period of disability commencing on or after the date in Item 8, above, include the from and *through dates — this will not include the day on which the employee returned to work.* Or, the "through" date could be the 45th day of COP, or the day prior to the day COP was terminated for cause.
19. Enter appropriate dollar amount.
20. Self-explanatory.
21. If pay rate has changed, enter new base pay; and night differential, Sunday premium and COLA as applicable.
22. Self-explanatory.
23. Title and *commercial* telephone number.
24. Self-explanatory.

Report of Termination of Disability and/or Payment

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

Part - A General

1. Name of Injured Employee (last, first, middle) | 2. Social Security Number | 3. OWCP File Number (If known)

4. Department or Agency | 5. Bureau or Office

6. Name and Address of Reporting Office (Include Zip Code)

7. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM

8. Date and Hour Stopped Work (Mo., day, year) ☐ AM ☐ PM

9. Date and Hour Pay Stopped (Mo., day, year) ☐ AM ☐ PM

10. Date and Hour Returned to Work (Mo., day, year) ☐ AM ☐ PM

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday

S M T W T F S

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

13. Inclusive Dates Employee Received Pay For any Part of The Period of Absence Reported

a. Annual Leave	b. Sick Leave	c. Other (Specify)
From: Through:	From: Through:	From: Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?

☐ Yes ☐ No If Yes, Describe The Type of Work Employee Is Performing.

15. If Reemployed, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year)

Health Benefit | Optional Insurance

16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year)

Number _____ Date _____

17. Remarks

Part - B Condensation of Pay

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year)

From Through

19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave.

$

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)

21. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Give New Rate

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

22. Signature of Supervisor | 23. Title and Office Phone Number | 24. Date (Mo., day, year)

Form CA-1
Rev. June 1988

INSTRUCTIONS FOR COMPLETING FORM CA-3 WHEN EMPLOYEE RETURNS TO WORK

PART - A

REQUIRED WRITTEN REPORT

- When disability ceases and/or employee returns to work, the official superior shall immediately report this fact to the OWCP on Form CA-3 unless this information has been previously submitted on Form CA-1 or CA-2 or otherwise. This form should be submitted for each injury requiring medical treatment or time lost from work whether or not claim for compensation is made.

TELEPHONE/ TELEGRAPH REPORT

- If the employee is receiving disability compensation periodically each four weeks, the official superior should immediately telephone or telegraph the OWCP advising the date employee returned to work. This will avoid an overpayment of compensation. Follow-up should then be made with Form CA-3.

PAY RATE INFORMATION

- Employee's base pay in items 12a or 21a should not include value of subsistence, quarters or other pay. These should be shown separately in their own columns.

PART - B

CONTINUATION OF PAY

- In most traumatic injury cases, the employee will have options for and received continuation of pay under 5 USC 8118 (FECA). When this occurs, items 8, 13, and 15 in Part A will usually be left blank. When there is a continuation of pay, Part B must always be completed unless the information has been submitted on Form CA-1, Claim for Compensation on Account of Traumatic Injury.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

OWCP Form CA-5 Instructions

Claim for Compensation By Widow, Widower, and/or Children

Summary

Purpose

General Procedures and Preparation Responsibilities

a. The control office provides the survivor(s) with a blank CA-5. The ICCO should be sure that the survivor is apprised of the death benefits listed on the CA-5 and that he or she understands the instructions for completing the form. Also be sure that the survivor is aware that all legal documents such as marriage and death certificates should be certified with a raised seal. Such seals can normally be impressed by the issuing authority.

b. After the survivor has completed the form, and has had the Attending Physician's Report completed, all forms and supporting documents should be submitted to the ICCO for review and submission to the OWCP.

c. If death resulted from an injury or illness previously reported or accepted by the OWCP, enter the OWCP file number on the upper right corner of the form.

d. If it is a new case, not previously reported, the supervisor will be required to prepare and submit a Form 1769, *Accident Report.*

e. The utmost consideration and assistance should be given to the survivor(s).

Note: Completing the form may be difficult for some, but a qualified injury compensation person should be able to provide completion guidance since the form has been developed to assist the survivors by its simplicity.

Death benefits for survivors are summarized on the CA-5. This can be used to provide the survivors with information they will probably want to know and could relieve them of some note-taking.

Timeliness

Form CA-5 should be submitted to the Agency by the survivor within 30 days of the death, if possible, but not later than 3 years after the death. If the death resulted from an injury for which a disability claim was timely filed, the time requirements for filing a death claim have been met.

Filing and Distribution

To distribute and file form CA-5, do the following:

a. Forward the originals of all forms or documents to the OWCP immediately upon receipt.

b. Make copies of all documents filed in the ICCO file.

Claim for Compensation by Widow, Widower, and/or Children

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

OMB NO. 1215-0155
Expires: 04-30-95

1. Name of deceased employee (Last, first, middle) | 2. Date of Birth (Mo., day, year) | 3. Date of Injury (Mo., day, year) | 4. Date of Death (Mo., day, year) | 5. Social Security Number

6. Name and address of employing agency (Include ZIP Code) | 7. Nature of injury which caused death

Claim of Surviving Husband or Wife (Items 8 through 13)

8. Name and address (Include ZIP Code) | 9. Your Date of Birth (Mo., day, year) | 10. Date of Marriage to Employee (Mo., day, year)

11. Were you living with the employee at the time of death?
☐ Yes ☐ No

12. Were you ever married to anyone other than the employee?
☐ Yes ☐ No

13. Was employee ever married to anyone other than you?
☐ Yes ☐ No

14. List all of employee's children from this marriage who may be entitled to compensation (See attached information sheet for definition of children):

Name	Relationship	Date of Birth	Address (Include ZIP Code)

15a. List all of employee's children from prior marriages who may be entitled to compensation

Name	Relationship	Date of Birth	Address (Include ZIP Code)

15. If a legal guardian has been appointed for any child named above, give name of child, name and address of the guardian.

Child	Guardian	Guardian's Address (Include ZIP Code)

16. List other relatives who were fully or partially dependent on employee:

Name	Relationship	Date of Birth	Address (Include ZIP Code)

17. If employee was ever in the Armed Forces of the United States, give
Service number
Branch of service
Period of service

18. If application has been made for Veterans Administration (VA) benefits because of employee's death, give
VA Claim number:
Address of VA office where claim is filed

19. If application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give
Claim Number
Date Annuity began
Amount paid per month: $

20. If a claim has been made against a third party because of employee's death, give
Amount of recovery: $
Name and address of third party

21. Total burial expense: $

22. Amount of burial expense paid or payable by VA: $

23. Name and address of party (other than VA) whose funds were used to pay burial expense and amount paid: $

I hereby certify that each and every statement made above is true to the best of my knowledge.

24. Signature of person filing claim

25. Address (Include ZIP Code)

26. Date (Mo., day, year)

Form CA-5
Rev. Mar. 1989

Attending Physician's Report

1. Name of deceased employee (Last, first, middle)

2. Date of death (mo., day, year)

3. What history of injury or employment related illness was given to you?

4. If related to illness, give diagnosis

5. If death was not natural/about, describe the treatment you provided

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? ☐ Yes ☐ No
Give the medical reasons for your opinion, unless causal relationship is obvious.

10. Was a biopsy or an autopsy performed?
If yes, give name and address of physician and attempt to a copy of the report to be submitted
☐ Yes
☐ No

11. Name and address (Please type - include ZIP Code)

12. Signature

13. Date signed (Mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

Who Should File Claim

- This claim form should be completed and filed by the widow or widower to file and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.

When Should Claim Be Filed

- Claim must be filed within three years following date of death, unless the employee's immediate supervisor had actual knowledge of the death or injury or death within 30 days or written notice of the injury or death was given within 30 days. The timely filing of a disability claim will satisfy the time requirements for a death claim based on the same injury.

What Documents Are Required

- The marriage certificate(s) for a widow or widower death certificate for deceased to previously submitted. Birth certificate or adoption documents for each child. Also, if appropriate, letter of guardianship, if other than the deceased or the surviving spouse was previously named. Age documents showing dissolution of such prior marriage(s). Copies of certifiable documents are acceptable only if they are certified by the person having official custody of such records. They should not be submitted to the claim form when mailed.

How to Complete Claim

- All items should be completed. If an item is not applicable, indicate by entering "Not applicable" or "N/A". Item 1 requests information about several different categories of persons. Item 1 must be completed to indicate the surviving widow or widower, the surviving children, and/or the children's guardian. The attending physician's report on the treatment of the claimant must also be completed before the form is submitted to the OWCP.

Claimant Must Authorize

- Submit original, non-photocopied, signature. Please do not initial and give name and address of person who may receive information, or payment on claimant's behalf. If such person's name and address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Form CA-5
Rev. May 1980

DEATH BENEFITS FOR SURVIVING WIDOW, WIDOWER AND/OR CHILDREN UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT (FECA)

Widow or widower	■ To qualify for benefits, a widow or widower must have been living with the employee or receiving support from the employee at the time of death. If remarriage occurs prior to the annual death payments continue for life of unremarriage. Upon remarriage, a widow or widower will receive a lump sum equal to 24 times his or her monthly compensation. If the remarriage occurs at age 60 or after, no lump sum is paid. Upon remarriage, payments continue for life.
Children	■ Eligible children include natural, adopted, step and posthumous children unmarried and under 18 years of age. Payments continue beyond 18 if the child is incapable of self-support because of mental or physical incapacity. Payments also continue on behalf of children over 18 if they are full-time students. Student benefits terminate upon marriage completion of four years of education beyond high school level, or at age 23, whichever occurs first.
Compensation Rates	■ For a widow or widower - 35% of the employee's monthly pay if there are no surviving eligible children; 45% if there are eligible children. Children - 15% each, not to exceed a total of 85%, shared equally if there is a widow or widower; if there is no widow or widower, 45% for one child plus 15% for each additional child, shared equally. Monthly payments for all beneficiaries cannot exceed 75% of the employee's monthly pay rate, or 75% of the top step of GS-15 of the General Schedule.
Funeral/Burial Allowance	■ Funeral and burial expenses up to a maximum of $800 may be paid. Amount paid by the Federal government may be deducted if death occurs away from the employee's duty station. Transportation costs may be paid in connection with bringing an employee's remains to the place of his or her home of record. In addition to any funeral or burial expenses, a sum of $200 may be paid for reimbursement of the costs of termination of the decedent's status as an employee of the United States.
Third Party Action	■ In the event of death resulting from injuries of a person or party other than the Federal Government, a third party action or suit may be undertaken. In such instances, the Department of Labor will provide further information.

If additional information is needed, it may be obtained from the Office of Workers' Compensation Programs.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N-1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and to the Office of Management and Budget, Paperwork Reduction Project (1215-0051), Washington, D.C. 20503.

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

OWCP Form CA-5b Instructions

Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

Summary

Purpose

Claims compensation on behalf of those relatives named above, who were wholly or partially dependent on the deceased.

General Procedures and Preparation Responsibilities

a. The ICCO provides *each* claimant a CA-5b — *a separate form is required for each person claiming benefits.* The ICCO should be sure that the claimant(s) is apprised of the death benefits listed on the CA-5b and that they understand the instructions for completing the form. Also be sure that the claimant is aware that all legal documents such as marriage and death certificates should be certified with a raised seal. *In the event that the deceased is survived by a spouse or children, be sure that the claimant(s) is aware of the payment priorities listed under the death benefits section of the form.*

b. After the claimant has completed the form, and has had the Attending Physician's Report completed, all forms and supporting documents should be submitted to the ICCO for review and submission to the OWCP.

c. If death resulted from an injury or illness previously reported or accepted by the OWCP, enter the OWCP file number on the upper right corner of the form.

d. If it is a new case, not previously reported, the supervisor is required to prepare and submit a Form 1769, *Accident Report*.

Timeliness

This form should be submitted to the Agency by the survivor within 30 days of the death, if possible, but not later than 3 years after the death. If the death resulted from an injury for which a disability claim was timely filed, the time requirements for filing a death claim have been met.

Filing and Distribution

For filing and distributing, do the following:

a. Forward the originals of all forms or correspondence to the OWCP.

b. File copies in ICCO claim file.

Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren

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

OMB No. 1215-0155
Expires: 06-30-98

1. Name of deceased employee (Last, First, middle)	2. Date of Birth (Mo., day, year)	3. Date of Injury (Mo., day, year)	4. Date of Death (Mo., day, year)	5. Social Security No./OCD

6. Name and address of employing agency (Include ZIP Code)

7. Nature of injury which caused death

8. Name of dependent (Last, first, middle)

9. Dependent's address (Include ZIP Code)

10. Dependent's birth date (Mo., day, year)

11. Dependent's Occupation

12. Dependent's Social Security Number

13. Dependent's relationship to employee

14. Extent of dependency on employee
☐ Total ☐ Partial

15. Total amount employee contributed to dependent's support during 12 months immediately prior to death.
$

16. Did employee live with dependent during the 12 months immediately prior to death?
☐ Yes ☐ No
If "Yes", Complete 17 & 18

17. Total amount employee paid dependent in money or labor for room and board in addition to amount shown in 15.
$ ____ Per ____

18. If no fixed amount was paid for room and board, enter in the fair value of such room and board?
$ ____ Per ____

19. If dependent was employed during 12 month period prior to employee's death, give:
Type of work performed.
Period of employment
Monthly pay rate
Name and address of employer:

20. Show dependent's income from all sources other than employment during 12 month period prior to employee's death:
Investments $
Pensions
Persons other than employee
Other
Total $

Information about dependent's husband or wife (Items 21 through 25)

21. Birth Date (Mo., day, year)	22. Occupation	23. Monthly pay rate	24. Total income from all sources for 12 months prior to employee's death
		$	$

25. List all property owned by dependent and husband or wife (cash, clothing, furniture, personal items)

Description	Date Acquired	Value

26. If employee was ever in the Armed Forces of the United States, give:
Serv ce Number:
Branch of service.
Period of service

27. If an application has been made for Veterans Administration (VA) Benefits Because of employee's death, give:
VA Claim number:
Address of VA office where claim is filed

28. If an application has been made for U.S. Civil Service Annuity or any other Federal Retirement or Disability Law because of employee's death, give:
Claim Number
Date Annuity began
Amount paid per month: $

29. If a claim has been made against a third party because of employee's death, give:
Amount of recovery: $
Name and address of third party.

30. Total burial expenses

31. Amount of burial expenses paid or payable by VA
$

32. Name and address of party (other than VA) whose funds were used to pay burial expenses and amount paid:
$

I hereby certify that each and every statement made above is true to the best of my knowledge. 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 felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

33. Signature of person filing claim

34. Address (Include ZIP Code)

35. Date (Mo., day, year)

Form CA-5b
Rev. [illegible]

Attending Physician's Report

1. Name of deceased employee (Last, First, Middle)

2. Date of death (Mo., day, year)

3. What history of injury or employment-related disease was given to you?

4. If treated for disease, give diagnosis

5. If death was not instantaneous, describe the treatment you provided

6. Show dates on which treatment was given.

7. What was the direct cause of death?

8. What were the contributory causes of death, if any?

9. In your opinion, was the death of the employee due to the injury as reported in item 3 above? Give the medical reasons for your opinion. Unless causal relationship is obvious. ☐ Yes ☐ No

10. Was a autopsy or an autopsy performed? Arrange for a copy of the report to be submitted. ☐ Yes ☐ No

11. Name and address (Please type - include Zip Code)

I certify that all statements in responses to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any knowingly false or misleading statement or concealment of material fact may subject me to felony criminal prosecution.

12. Signature

13. Date signed (Mo., day, year)

OWCP Form CA-6 Instructions

Official Superior's Report of Employee's Death

Summary

Purpose

Notifies OWCP of the employment-related death of an employee.

General Procedures and Preparations Responsibilities

Note: When an employee dies because of either a traumatic injury or an occupational disease or illness, the ICCO will notify the OWCP district office immediately by telephone or telegram (20 CFR 10.103, ELM 542.211).

a. Upon the death of an employee, the ICCO must be *immediately* notified.

b. After investigation and acquisition of a certified copy of the death certificate, the ICCO will complete the form.

c. If death resulted from an injury or illness pre-reported to the OWCP, enter the OWCP file number on the upper right corner.

Filing and Distribution

CA-6 is filed and distributed as follows:

a. Send the original form to the OWCP as soon as practicable, but within 10 days from the date of receipt of knowledge of the death (20 CFR 10.103).

b. Place a copy in the ICCO file.

c. Send a copy to the Safety Office.

d. Forward a copy to the area Human Resources manager.

Instructions

This form will be completed by the ICCO with input from the decedent's immediate supervisor.

1. Decedent's complete name; last name, first name, and *middle name* (enter "NMN" if no middle name).
2. *Claimant's date of birth* — Not today's date or current year.
3. Verify sex.
4. SSN consists of *nine* digits.
5. U.S. Postal Service
6. OWCP Agency Code
7. Leave blank

8. Address of control office authorized to forward or communicate with the OWCP.
9. Self-explanatory; however, it may be best to enter the name and telephone number of the injury compensation control officer.
10. Month, day, year, and *time* of *injury.*
11. Month, day, year, and *time* of *death.*
12. Month, day, year, and *time* the employee's pay was stopped; this will normally be the first scheduled tour of duty following the death.

    Note: If the employee was in a duty status at the time of death, the *remainder of the scheduled day is charged to administrative leave.*
13. Enter a complete description of events leading up to and including the injury. Use an attachment if necessary.
14. If decedent was on duty at time of injury check *Yes*. If not on duty, or not in the performing a duty, check *No* and explain.
15. Name of office, branch, station, or facility (include pay location) where decedent was employed. *Exact* location where injury occurred. If off postal premises, identify the street address, location on property or street, etc. If on postal premises, identify the building and/or room, location, work area, column, grid, parking lot location, stairwell, etc.
16. Identify *specific location* where death occurred; worksite (see Item 15), hospital, at home, etc.
17. Do not complete unless either a death certificate, medical report, or an autopsy report is available.
18. Enter decedent's grade and level in block 18. Enter annual or hourly base pay (includes contractual COLA). in 18a. Compute, as applicable, regularly scheduled night differential and Sunday premium pay and enter in 18d.

    Note: If decedent was entitled to territorial COLA, enter the dollar amount per annum or hour in 18c and identify.
19. Self-explanatory.
20. Check *No* only if the employee was a casual or a temporary employee.
21. a. Enter the beginning and ending dates of any annual or sick leave used. If time loss was intermittent, attach a list of dates and type leave used each date or period.

    b. Enter any date(s) the decedent received holiday or administrative pay in 18c and identify.
22. a, b, and c. To be completed by the ICCO.
23. a. Enter COP rate if paid; to include base, night differential and Sunday premium if applicable, and territorial COLA, if applicable.

b. The *From* date will be the date on which the 45-day count began, whether or not it was a scheduled workday. The *To* date should be either the 45th day of COP, the last date COP was paid, or the date of death.

24. Self-explanatory.

25. Enter the last day of the pay period in which health benefit deductions were made.

26 – 30. Self-explanatory.

31. Has claim been filed by survivor(s) with the Office of Personnel Management; ascertain by contacting your personnel office.

32 – 35. Self-explanatory.

Official Superior's Report of Employee's Death

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

1. Name of Deceased Employee (Last, first, middle)
2. Date of Birth (Mo., day, year)
3. ☐ Male ☐ Female
4. Social Security No.
5. Department or Agency
6. OWCP Agency Code
7. OWCP File Code
8. Name and Address of Reporting Office
9. Name and Office Phone Number of Employee's Official Superior
10. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM
11. Date and Hour of Death (Mo., day, year) ☐ AM ☐ PM
12. Date and Hour Employee's Pay Stopped (Mo., day, year) ☐ AM ☐ PM
13. Describe how injury occurred
14. Was employee in performance of duty when injury occurred? ☐ Yes ☐ No (If No, explain)
15. Location where injury occurred
16. Location where death occurred
17. Immediate cause of death (Attach medical and autopsy report if available)
18. Employee's pay rate as of

	a. Base pay	b. Subsistence	c. Quarters	d. Other
A. Date of Injury	$ per	$ per	$ per	$ per
B. Date pay stopped	$ per	$ per	$ per	$ per

19. Did employee work in position held at time of injury for a full eleven months immediately prior to the injury? ☐ Yes ☐ No
20. If answer to 19 is no, would position have afforded employment for eleven months except for the injury? ☐ Yes ☐ No
21. Did employee receive leave pay for any part of period from time pay stopped to date of death? (Give inclusive dates)
From To
22. a. Occupation code
b. Type code
c. Source code
23. Did employee receive commutation of pay (COP) during period prior to death?
a. Pay rate used for COP
$ per
b. Inclusive dates of COP
From To
OWCP use - NOI code
24. If employee was enrolled in Federal Employees Health Benefits Plan list self and family, show HBS Code Number
25. Show date through which HBS deductions were last made (Mo., day, year)
26. If employee received medical care prior to death, give name and address of attending physician
27. If injury was caused by a third party, give name and address of third party
28. Give name and address of the attorney representing the survivor if legal action is instituted against the third party
29. Show amount of third party recovery, if any
$
30. If employee was a member of the Armed Services of the United States, show
Branch of Service:
Serial No. (If known)
31. Has claim for survivor's benefits been filed with the Office of Personnel Management?
☐ Yes ☐ No
32. Name and address of employee's spouse or next of kin (Show relationship, if other than spouse)
33. Signature of Official Superior
34. Title
35. Date (Mo., day, year)

Form CA-6
Rev. Nov. 1988

Instructions for Completing Form CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate, when submitted to OWCP.

Form CA-5 or CA-5b should be supplied to the employee's spouse or next of kin.

If additional space is required, attach separate sheets and number the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter S10, Injury Compensation, Federal Personnel Manual.

Box 22a (Occupation Code), Box 22b (Type Code), Box 22c (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.

OWCP Form CA-7 Instructions

Claim for Compensation on Account of Traumatic Injury or Occupational Disease

Summary

Purpose

CA-7 serves to claim compensation or schedule award for any of the following:

a. A wage loss for a period of disability, which is greater than three days, resulting from either a traumatic injury or an occupational disease.

b. A schedule award for permanent impairment of a member or function of the body which resulted from either a traumatic or an occupational injury.

c. A loss in wage-earning capacity, i.e., when the employee has been permanently reassigned to a lower level position without saved pay, and the reassignment was due to permanent partial disability resulting from either a traumatic or an occupational injury.

d. A request of a buy-back of personal leave used during periods when OWCP compensation was authorized.

When to Prepare

The form is prepared when either disability for work extends beyond the authorized period of continuation of pay (COP), or, when compensation is requested for disability and/or absences from work due to an occupational claim.

General Instructions and Preparation Responsibilities

To prepare the CA-7, ensure that the following steps are completed:

1. The ICCO provides the employee a CA-7 as required or requested.
2. The employee or representative completes Items 1–20 and returns the completed form to the control office/point.
3. The *employee* is responsible for having the attached CA-20 completed by the treating physician and submitting it to the control office or point.
4. The control office completes Items 21–38, as required. If the employee does not enter his or her file number in Item 2, the ICCO should enter it, if it is available.

When an employee is in COP status and medical evidence indicates that the period of total disability will extend more than 3 days after the 45th day of COP, the ICCO will initiate the following procedures.

(1) Provide a CA-7, with the CA-20 attached, to the employee after the 30th day of COP. Instruct the employee to return the completed forms within 7

calendar days to preclude interruption of pay. The entire period of disability supported by competent medical authority may be claimed on the CA-7.

(2) The ICCO will forward the completed CA-7 and CA-20 to the OWCP by the 40th calendar day of COP. If the CA-20 has not been returned with the CA-7, submit the CA-7 to the OWCP and advise them that the employee has not returned the required medicals.

When an employee is disabled due to a traumatic injury but is ineligible for COP, a CA-7 may be initiated after 3 days of disability and the employee may either enter a LWOP status or use sick or annual leave. If personal leave is used, the employee will be advised of the buy-back procedures.

When disability is realized following the submission of a CA-2 for an occupational illness or disease, the CA-7 will be sent to the OWCP, along with medical evidence if not already submitted, no later than 5 days after the period claimed for compensation (Item 4).

Filing and Distribution

For filing and distribution, do the following:

a. Send the original CA-7, CA-20, and medical reports to the OWCP by the control office.

b. File a copy of the forms submitted in the claimant's injury compensation file.

c. Provide copies of the medical reports to the medical or health unit as appropriate.

Note: If disabled, and the employee returns to work prior to the submission of Form CA-7, completion of Item 33 will eliminate the need for filing a Form CA-3. However, if your local OWCP District Office requests a CA-3, submit.

Instructions

A. Items 1–20 will be completed by the employee or representative.

1. Claimant's *complete* name; last, first, middle. Enter "NMN" if no middle name.
2. If either a traumatic claim (CA-1) or an occupational claim (CA-2) has been submitted, enter the file number, if it is available.
3. SSN consists of 9 digits.
4. Enter inclusive dates covering the period(s) for which compensation is being claimed. If intermittent periods are claimed, use separate sheet to list each period.

   In the block following Item 4, identified as "Hours," enter the exact number or *work* hours within the period(s) for which compensation is being claimed.

5. If the CA-7 is being submitted to request a scheduled award in accordance with 5 U.S.C 8107, check *Yes*. *If a scheduled award is claimed, Items 4, 6, and 7 are not completed and such claim should not include a claim for compensation.*
6. Check *Yes* if pay was received for either personal leave (annual/sick or for work performed *for anyone* during the period(s) listed in Item 4). This must include the Postal Service, other federal agencies, private industry, or *self-employment*.
7. If *no* income was received from *any* source during the period listed in Item 6, enter "NA."
8. a. If pay was received during the period(s) listed in Item 4, *enter actual pay received, before deductions*. If income was received from non-USPS employment, list each source separately with the related, gross pay received, and enter the period of employment for periods(s).
   b. If self-employed and a salary or wage is not paid, claimant will enter the salary or wage which would have been paid to an employee of the claimant performing similar duties for the same number of hours.
9. Was a claim, or will a claim, be made against a third party responsible for the claimed injury or illness. Check appropriate box.
10. Self-explanatory.
11. If a third party claim has been settled, enter the gross recovery. If a third party case has not been settled, enter "Pending."
12. Check appropriate box. If *Yes*, complete *a, b,* and *c*. If block *c* is completed, be sure that the specific disability for which VA compensation is being provided is identified.
13. Check appropriate box. If *Yes*, complete *13a, b,* and *c*.
14. A wife or husband is a dependent if he or she is living with the claimant. A child is a dependent if he or she either lives with or receives support payments from the claimant, and he or she: (1) is under 18; or (2) is between 18 and 23 and is a full-time student; or (3) is incapable of self-support due to physical or mental disability. If space is insufficient to list all dependents, add a continuation sheet.
15. Indicate if employee is making support payments for dependents listed in Item 14.
16. If support payments are ordered by a court, a copy of the court order must be attached.
17. If Item 16 is *Yes*, complete this Item, completely, for each person the claimant is making support payments. Use additional sheets if necessary.
18. Include the specific amount of support paid (per week, month, etc.) for *each* person listed in Item 17.

19. Be sure that the claimant has read and understands the certification statement and *penalty statement*. In addition, show the claimant the *Privacy Act* statement, contained on the back of the instruction page.

20. Self-explanatory

B. Items 21–38 will be completed by the ICCO.

21. Enter claimant's grade and level or step, and appropriate date(s) if applicable.
    - If claimant is either a bargaining unit full-time or part-time regular, enter annual salary in Item 21a.
    - If claimant is either a bargaining unit part-time flexible or irregularly scheduled career employee, enter the average weekly pay for the preceding year, or for the period of employment if employed for less than one year.
    - If claimant is a casual (NTE) employee, enter the hourly wage.
    - If claimant is a salaried, non bargaining unit employee, enter annual salary.
    - If claimant is entitled to Territorial COLA , enter amount in Item 21.d and identify entry as "COLA."

22. If a claimant was paid either Sunday premium or nighttime differential, compute amount of each category paid during either the previous year, or, for the period of employment if employed for less than one year. If Item 21 was reported:
    - By annual salary, enter gross amount of each premium each per annum.
    - By average weekly pay, enter average amount of each premium paid per week.

Note: Casual (NTE) employees do not receive premium pay.

23. Self-explanatory.

24. Self-explanatory.

25. Answer *No* if employee is a casual or other type of temporary hire.

26. Self-explanatory.

Note: Those ICCO with WCIS terminals may also access the DDE/DR system to obtain the data for Items 27 and 28.

27. Check appropriate box.

    If *Yes* is checked, provide appropriate 3 character code. Refer to claimant's OPF.

    Enter the last date of the last pay period from which health benefits and optional life insurance (OLI) deductions were made. If deductions did not stop, enter "Not interrupted."

28. Refer to Standard Form 2817 in claimant's OPF.

29. *Note: These entries should agree with the dates shown in Item 4.*

    If, during period(s)of disability, the employee used either sick or annual leave, enter specific dates by category of leave. If employee received holiday or administrative leave pay, indicate periods of same and type of leave.

30. Enter period(s) of COP. If claim is due to an occupational disease or illness, this Item does not apply.

31. Enter month, day, year, *and time* employee entered a LWOP status.

32. Refer to Item 4.

33. If claimant did not stop work, enter "NA."

    If claimant lost time from work and has returned, enter the *date and time* for each period of disability alleged or reported as being due to the condition claimed. Return date(s) and time(s) should compliment Items 4 and 32.

34. If claimant did not stop work, enter "NA."

    If claimant did not stop work but has not returned, enter "Has not returned."

    If claimant returns to work with the same workday schedule as shown in Item 23, enter "Refer to Item 23."

    If claimant returns to a new workweek schedule that is fixed, circle days scheduled.

    If claimant has a variable or rotating schedule, enter either "variable" or "rotating" and circle days scheduled during week of return to work.

35. If claimant did not stop work, enter "NA."

    Check the appropriate box and if the work assignment has changed due to the injury, describe the new position or assignment by attaching a copy of either the limited duty or rehabilitation job offer.

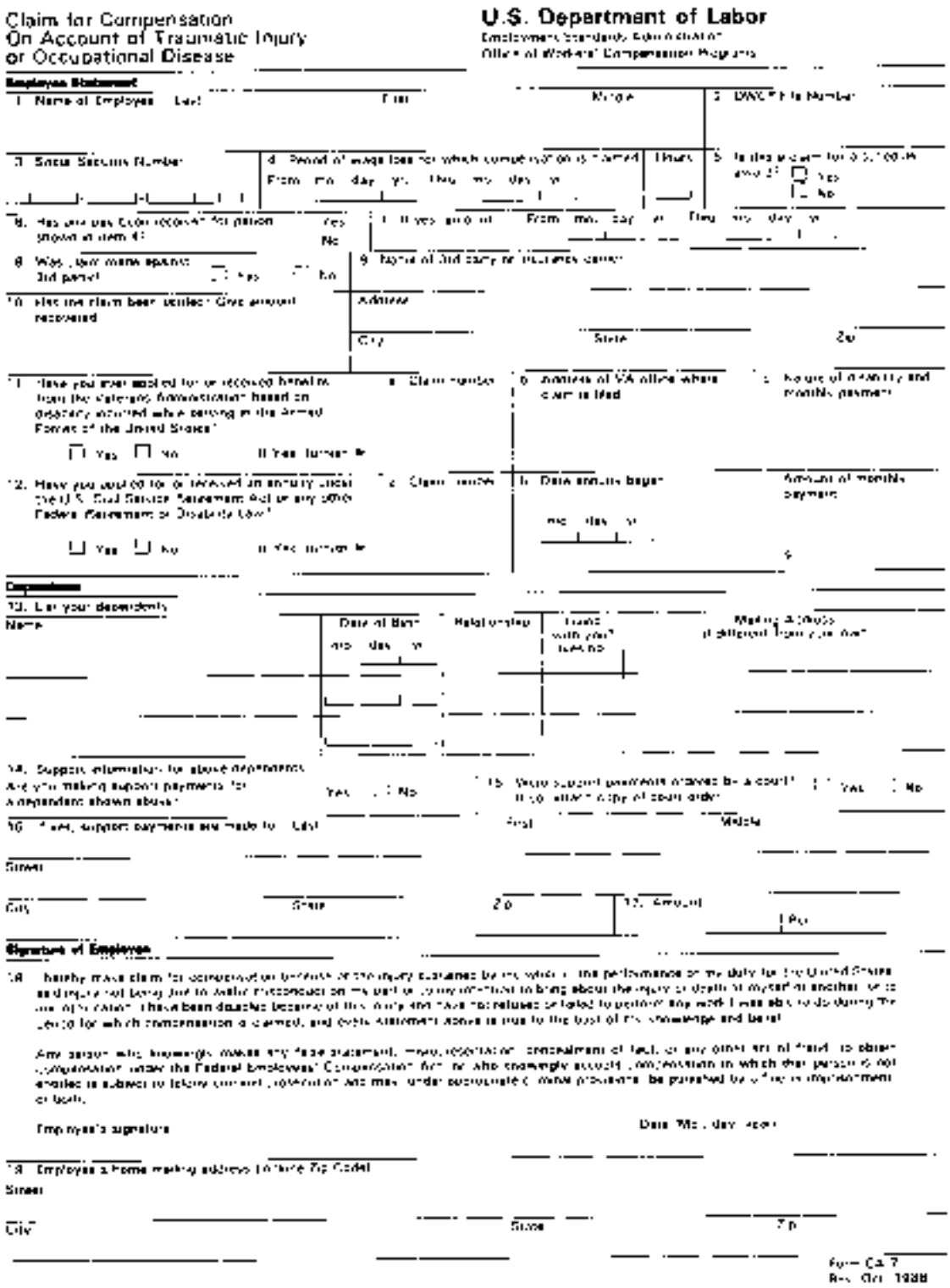
36. If claimant did not stop work, enter "NA."

    If claimant did stop work but has not returned, enter "Has not returned."

    If claimant did stop work, enter pay information if different from Item 21; or, if same as 21, refer to the appropriate entry.

37. Before completing the form, the person completing it should read the certification notice in Item 37; and, if the supervisor cannot so certify, he or she should provide specific documentation/information. Enter commercial telephone number.

38. Self-explanatory. Enter commercial telephone number.



Claim for Compensation
On Account of Traumatic Injury
or Occupational Disease

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

Employee Statement

1 Name of Employee Last First Middle

2 OWCP File Number

3 Social Security Number

4 Period of wage loss for which compensation is claimed From mo. day yr. Thru mo. day yr. Hours

5 Is this a claim for a death benefit? ☐ Yes ☐ No

6 Has any part been accepted for injury shown at item 4? Yes No If yes, give date From mo. day yr. Thru mo. day yr.

7 Was your name against 3rd party? ☐ Yes ☐ No

8 Name of 3rd party or business name

9 Address City State Zip

10 Has the claim been settled? Give amount recovered

11 Have you ever applied for or received benefits from the Veterans Administration based on disability incurred while serving in the Armed Forces of the United States? ☐ Yes ☐ No If Yes, furnish a. Claim number b. Address of VA office where claim is filed c. Nature of disability and monthly payment

12 Have you applied for or received an annuity under the U.S. Civil Service Retirement Act or any other Federal Retirement or Disability Law? ☐ Yes ☐ No If Yes, furnish a. Claim number b. Date annuity began Amount of monthly payment mo. day yr. $

Dependents

13. List your dependents

Name | Date of Birth mo. day yr. | Relationship | Lives with you? Yes/No | Mailing Address (if different from yours)

14. Support information for above dependents

Are you making support payments for a dependent shown above? Yes No

15 Were support payments ordered by a court? Yes No If yes, attach a copy of court order

16 If not, support payments are made to Last First Middle

Street

City State Zip

17. Amount ($) Per

Signature of Employee

18 I hereby make claim for compensation on account of the injury sustained by me while in the performance of my duty as I verily believe and injury not being due to my willful misconduct or my intention to bring about the injury or death of myself or another, or to my own culpable negligence. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed, and this statement above is true to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation under the Federal Employees' Compensation Act or who knowingly accepts compensation to which that person is not entitled is subject to [illegible] and may under appropriate criminal provisions be punished by a fine or imprisonment or both.

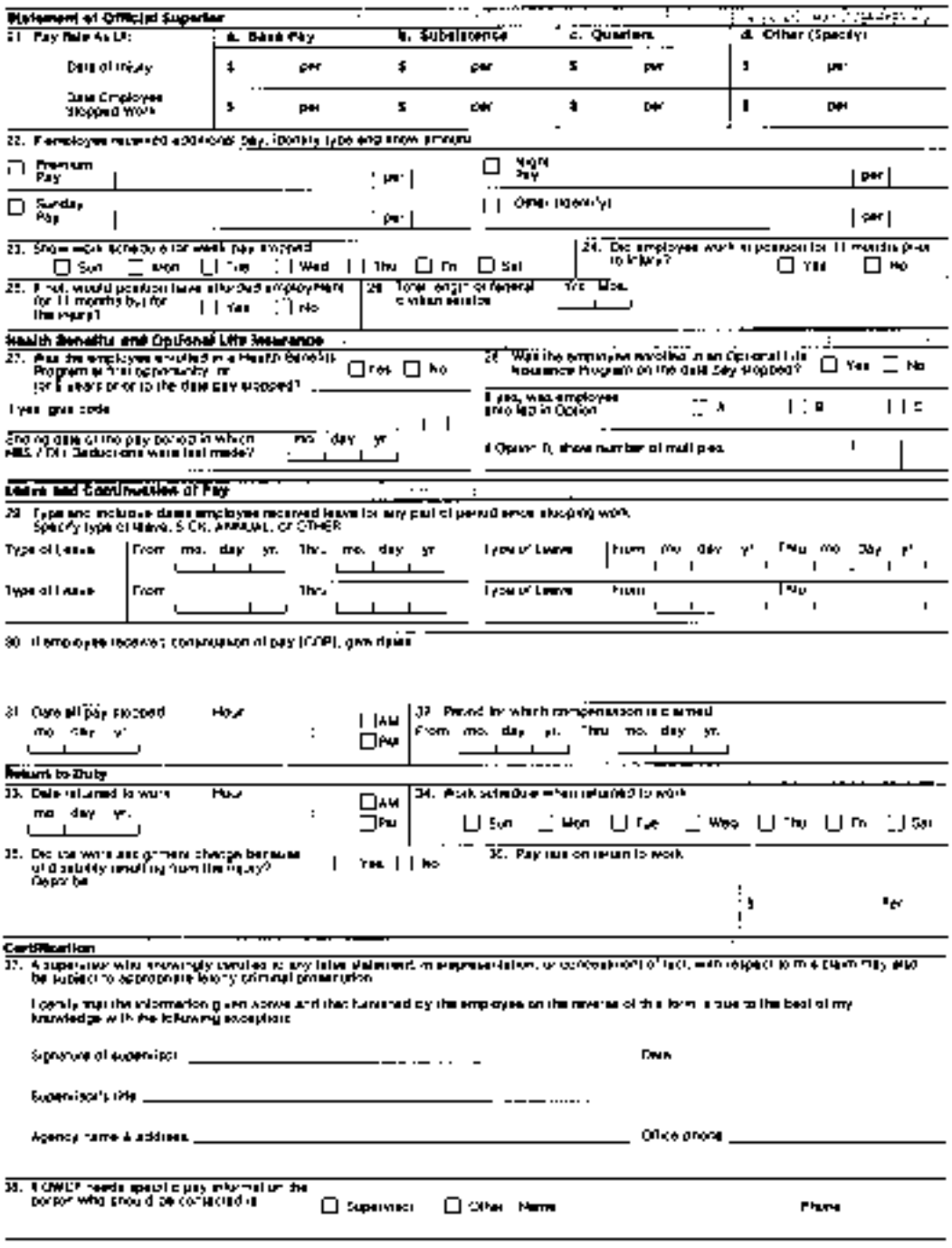
Employee's signature Date Mo., day, year

18 Employee's Home mailing address (Number, Street, City, State, Zip Code)

Street

City State Zip

Form CA-7
Rev. Oct. 1988



Statement of Official Supervisor

21. Pay Rate As Of:

	a. Basic Pay	b. Subsistence	c. Quarters	d. Other (Specify)
Date of Injury	$ per	$ per	$ per	$ per
Date Employee Stopped Work	$ per	$ per	$ per	$ per

22. If employee received additional pay, identify type and show amount.

☐ Premium Pay | per | ☐ Night Pay | per |

☐ Sunday Pay | per | ☐ Other (Identify) | per |

23. Show work schedule for week pay stopped
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

24. Did employee work in position for 12 months prior to injury? ☐ Yes ☐ No

25. If not, would position have also had employment for 12 months by, for the injury? ☐ Yes ☐ No

26. Total length of federal civilian service: Yrs Mos.

Health Benefits and Optional Life Insurance

27. Was the employee enrolled in a Health Benefits Program at first opportunity or for 5 years prior to the date pay stopped? ☐ Yes ☐ No

If yes, give code

Ending date of the pay period in which HBP / TSP Deductions were last made? mo day yr

28. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped? ☐ Yes ☐ No

If yes, was employee enrolled in Option ☐ A ☐ B ☐ C

If Option B, show number of multiples

Leave and Continuation of Pay

29. Type and inclusive dates employee received leave for any part of period since stopping work. Specify type of leave, S CK, ANNUAL, or OTHER

Type of Leave	From mo. day yr.	Thru mo. day yr.	Type of Leave	From mo. day yr.	Thru mo. day yr.
Type of Leave	From	Thru	Type of Leave	From	Thru

30. If employee receives compensation of pay (COP), give dates

31. Date all pay stopped mo day yr. Hour : ☐ AM ☐ PM

32. Period for which compensation is claimed From mo. day yr. Thru mo. day yr.

Return to Duty

33. Date returned to work mo day yr. Hour : ☐ AM ☐ PM

34. Work schedule when returned to work
☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

35. Does work assignment change because of disability resulting from the injury? Explain ☐ Yes ☐ No

36. Pay rate on return to work $ Per

Certification

37. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with 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 exceptions:

Signature of supervisor _____ Date

Supervisor's title _____

Agency name & address _____ Office phone _____

38. If OWCP needs special pay information the person who should be contacted is ☐ Supervisor ☐ Other Name Phone

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (COP), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

EMPLOYEE (or person acting on the employee's behalf) - Complete items 1 through 20 and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete items 21 through 34 and promptly forward the form to OWCP.

ITEM EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Item Number	Explanation
4) Period of Wage Loss for which Compensation is Claimed	Enter the dates corresponding the period for which you are claiming compensation (for example, if period is 01/01/96 - 01/14/96, use a separate sheet for each period indicated).
5) Is This a Claim for a Schedule Award?	Schedule awards are paid for permanent impairment to a member or function of the body. A claim for a schedule award should not be made on the same form as a claim for compensation for wage loss; rather, a separate CA-7 should be used.
6) Has Any Pay Been Received for Period Shown in Item 4?	This question includes leave pay and COP received from the Federal job in which you were injured and pay for work actually performed, whether or not Federal job in which you were injured or in other employment (including self-employment).
7) If Yes, Amount	Give the amount of pay received and the period for which it was paid. If there is more than one period, or more than one source of pay, explain fully on a separate sheet.
8) Was Claim made Against 3rd 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 who gave inappropriate instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
14) Number of Dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you and he or she: (1) is under age 18; or (2) is between 18 and 23 and is a full-time student; or (3) is incapable of self-support due to physical or mental disability.
22) Employee Received Additional Pay: Identify Type and Show Amount	"Additional Pay" includes night differential, Sunday premium, holiday premium and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
23) Type and Number of Hours Employee Received Leave for any Part of Period Since Stopping Work	Enter employee leave covering each period of leave. If leave was used for more than four individual periods, continue on a separate sheet. If leave was used for part of each day during a period, state how many hours were used per day. If the number of hours used per day varied, use a separate sheet for each day.
26) Dates of Pay Continuation (COP) During Period of Disability	Enter the period of Continuation of Pay (see form CA-1 for full explanation). If the injury was not a traumatic injury (reported on form CA-1), this item does not apply.
31) Date of Pay Stopped	No compensation is payable for temporary total disability until the employee enters a non-pay status (for which, if eligible, compensation or pay, including Leave Compensation, is not payable for the first three days of disability after the end of any COP unless the disability exceeds 14 calendar days.

OWCP Form CA-8 Instructions

Claim for Continuing Compensation on Account of Disability

Summary

Purpose

The purpose of Form CA-8 is used as the employee's claim for compensation when eligibility extends beyond the period claimed on Form CA-7. It also serves to request a buy-back of personal leave used during periods when OWCP compensation was authorized.

Preparation

This form is prepared when disability for work extends beyond the period claimed on either the CA-7 or on the previous CA-8. It should be submitted at the end of each pay period, until either:

a. The employee returns to full-day work; and/or medical appointments either cease or are not within the employee's normal work hours.

b. OWCP notifies the ICCO that the employee is being placed on the periodic rolls.

c. The employee elects OPM annuity instead of FECA compensation.

d. The employee's compensation benefits are terminated for cause.

General Procedures and Preparation Responsibilities

a. The ICCO provides the employee/representative a CA-8 as required/requested. The CA-20a will not be detached.

b. The employee is responsible for completing Items 1–14, and returning the completed form to the ICCO.

c. The employee is responsible for having the attached form CA-20a completed by the treating physician.

d. The ICCO completes Items 15–24, as required. If the employee does not enter his/her file number in Item 2, the ICCO should enter it.

e. The ICCO submits the completed form and the CA-20a/medical report to the OWCP office. Considering the nature of the injury/illness, a CA-20a and/or medical report is normally submitted each two weeks with the CA-8. If the CA-20a/medical report has not been returned with the CA-8, submit the CA-8 to the OWCP district office and advise the office that the employee has not submitted the required medicals.

Note: An employee may not be placed into a LWOP-IOD (code 49) timekeeping category unless the employer has been provided medical documentation certifying either disability caused by an on-the-job injury/illness, or the need for medical care/therapy during normal work hours of the claimant. If such medical documentation is not provided by the employee, code 49 may not be entered into the timekeeping system. Be advised that the periods of LWOP, code 60, are not creditable towards employment longevity; but, periods of LWOP-IOD, code 49, are creditable.

Special Procedures for Traumatic Injury Cases
(Refer to FPM Letter 810-6 (5-8-85)/FECA Circular 85-24 (9-20-85))

If disability caused by a traumatic injury is expected to last beyond the period of compensation claimed on either the CA-7 or the previous CA-8, CA-8 with the CA-20a attached, should be:

1. Provided to the injured employee in sufficient time for both forms to be completed, and,
2. Submitted to the ICCO for finalization and submission to the OWCP district office at least five days before the period covered by the previous CA-7 or CA-8 expires.

This procedure, for traumatic injuries, will continue until either:

1. OWCP notifies the ICCO that the employee has been placed on the periodic roll.
2. The employee returns to duty.

Filing and Distribution

Filing and distributing procedures are as following:

a. The ICCO sends the original CA-8, CA-20a and medical reports to the OWCP district office.

b. This ICCO files a copy of the forms submitted in the claimant's injury compensation file.

Instructions

A. Items 1–14 will be completed by the employee or representative.

1. Claimant's complete name; last, first, and middle (enter "NMN" of no middle name).
2. Self-explanatory.
3. Complete home mailing address, with Zip-4.
4. SSN consists of *nine* digits.

5. Date and time of original injury/disease; refer to either Item 10 of the CA-1 or Item 29 on the CA-2.
6. Lists first and last date for which compensation is being requested. The first date should be the first day following the ending date of the previous claim, either on a CA-7 or CA-8. The last date should be either the last day of the pay period, or the last day for which compensation is being claimed.
7. Check appropriate box; if *Yes* is checked, enter dates — if leave usage was during more than one period, list all such periods in attachment.
8. Before the employee makes a decision to initiate a buy-back, the ICCO should explain the "leave repurchase" or "leave buy-back" process.
9. a. This Item must be completed for *any* salary or wage earning work performed *for anyone* during the period claimed in Item 6

   b. Also, if self-employed and a salary or wage is not paid, claimant will enter the salary or wage which would have been paid to an employee of the claimant performing similar duties for the same number of hours. All commissions earned must also be listed.
10. Self-explanatory for employee; however, if during the period claimed in Item 6, the employee was presented an offer of limited duty and it was not accepted, so indicate in Item 20 and attach a copy of the job offer.
11. Employee must provide information relative to his or her application for VA benefits; to include application for a reevaluation of a condition for possible increased VA benefits due to the employment injury or illness. Cross-check this Item with Item 12 on the CA-7.
12. If employee has either applied for or received an OPM or other annuity, all data must be provided.
13. Be sure that the claimant has read the penalty notice in Item 13 before signing the form; refer to Item *c* in the *Instruction for Injured Employee*, located on the supervisor's side of the form.
14. Ensure that the date is accurate; however, if form was mailed, by either the claimant or the representative, *retain the envelope and affix to the claim form* retained in the ICCO.

B. Items 15–24 will be completed by the ICCO

15. Month, Day, Year, and time employee returned to work. If he or she has not returned at the time the CA-8 is submitted, enter "Has Not Returned."
16. If claimant returns to a fixed workday schedule, circle schedule days. If claimant returns to a variable or rotating schedule, enter either "Variable" or "Rotating" and circle days scheduled during week of return to work.
17. Self-explanatory.

18. Self-explanatory; however, compare dates/monetary figures in Items 6, 7, and 9.
19. Provide appropriate information if either health benefits or occupational life insurance coverage or premium payments have changed since the last claim for compensation was submitted on either a CA-7 or a CA-8.
20. Enter any comments which relate to either the entries made by the employee or to any attachments submitted with the claim.
21. No entry required unless the person signing Item 22 has information which conflicts with any of the employee's responses. If there is a conflict, enter the necessary information in this Item or prepare an attachment.
22. Signature of the supervisor or control office/point specialist or supervisor.
23. Self-explanatory.
24. Self-explanatory.

Claim for Continuing Compensation on Account of Disability

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

Statement of Injured Employee - See instructions on Reverse Side

1. Name of Injured Employee (Last, first, middle)

2. OWCP File Number, if known

3. Home Mailing Address (Include Zip Code)

4. Social Security Number

5. Date and Hour of Injury (Mo., day, year) ☐ AM ☐ PM

6. Period Compensation is Claimed as a Result of Pay Loss (Mo., day, year) If pay loss was intermittent attach separate sheet showing dates and hours of pay loss. From: Through

7. Have you received any leave pay during the period shown in Item 6? ☐ Yes ☐ No Show Inclusive Dates From: Through
If leave use was shown in item 7, attach separate sheet showing dates and hours used.

8. Do you wish to repurchase leave? ☐ Yes ☐ No

9. Complete this item if you worked anywhere during the period shown in item 6. Attach a separate sheet if needed.

a. Salaried Employment

Dates & Hours Worked	Pay Rate (Per Hour, Day or Week)	Total Amount Earned	Type Work Performed	Name & Address of Employer

b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts.

Dates & Hours Worked	Name and Address of Business	Self-Employed ☐ Commission ☐	Type of Activity Performed	Income Derived (Attach Explanation if Needed)

10. If you work only partially disabled and do not work, state reason for not working

11. If, since filing your initial claim for compensation, you have applied for or received VA Benefits based on Military Service for the United States, give the following.

Claim No. Date of Disability and Monthly Payment: Name and address of Office Where Claim is Filed

12. If, since filing your initial claim for compensation, you have applied for or received an annuity under the Civil Service Retirement Act or other Federal retirement or disability law, give the following.

Claim No. Amount of Monthly Payment: Name and Address of Office Where Claim is Filed

13. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF 14. Date (Mo., day, year)

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 criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Form CA-8
Rev. June 1994

Statement of Official Superior

15. If employee has not returned to work, show date and hour (Mo., day, year)
☐ AM
☐ PM

16. Show employee's work week or return to duty, if other than Monday thru Friday

S	M	T	W	T	F	S

17. Has employee received any pay for work, leave, subsistence, quarters or other remuneration from your agency during the period shown in item 8 on the reverse side?
☐ Yes ☐ No

18. If answer to item 17 is Yes, show:
Amount: $
Type of Payment:
Period: From: _____ Through: _____

19. If there has been any change in employee's health benefit enrollment and/or optional insurance since previous claim for compensation was submitted, please explain (i.e. change of plan or options; if additional deductions have been made by the agency show amount and period.)

20. Remarks

21. 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 or penal 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 exceptions:

22. Signature of Official Superior	23. Title	24. Date (mo., day, year)

Instructions for Injured Employee

a. Items 1 through 14 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $10,000, or imprisonment for not more than five years, or both.

d. The employee is responsible for submitting or arranging for the submission of medical evidence in support of this claim. The CA-20a is attached to form CA-8 for this purpose. The employee should complete items 1-8 on Form CA-20a. The attending physician should complete items 9 through 21. The address of the appropriate OWCP office should be inserted in item 3 on the reverse of the CA-20a.

Instructions for Official Superior

a. The official superior must complete items 15 through 24 and forward the form and any accompanying medical report, to the appropriate OWCP office within 5 working days of receipt from the employee.

If additional space is required to any reply a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

Note: Failure to submit this form properly completed with supporting medical evidence will delay payment of compensation.

OWCP Form CA-10

What A Federal Employee Should Do When Injured At Work

Report to Supervisor

Every job-related injury should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment, as well as damage to medical braces, artificial limbs and other prosthetic devices.

Obtain Medical Care

Before you obtain medical treatment, ask your supervisor to authorize medical treatment by use of form CA-16. You may initially select the physician to provide necessary treatment. This may be a private physician or, if available, a local Federal medical officer/hospital. Emergency medical treatment may be obtained without prior authorization. Take the form CA-16 and form OWCP-1500/HCFA-1500 to the provider you select. The form OWCP-1500/HCFA-1500 is the billing form physicians must use to submit bills to OWCP. Hospitals and pharmacies may use their own billing forms. Or, occupational disease claims form CA-16 may not be issued without prior approval from OWCP.

File Written Notice

In traumatic injuries, complete the employee's portion of form CA-1. Obtain the form from your employing agency, complete and turn it in to your supervisor as soon as possible, but not later than 30 days following the injury. For occupational disease, use form CA-2 instead of form CA-1. For more detailed information carefully read the "Benefits ..." and "Instructions ..." sheets which are attached to the Forms CA-1 and CA-2.

Obtain Receipt of Notice

A "Receipt of Notice of Injury" is attached to each Form CA-1 and Form CA-2. Your supervisor should complete the receipt and return it to you for your personal records. If it is not returned to you, ask your supervisor for it.

Submit Claim For COP/Leave and/or Compensation For Wage Loss

If disabled due to traumatic injury, you may claim continuation of pay (COP) not to exceed 45 calendar days or use leave. A claim for COP must be submitted no later than 30 days following the injury. The form CA-1 is designed to serve as a claim for continuation of pay. If disabled and claiming COP, submit to your employing agency within 10 work days medical evidence that you sustained a disabling traumatic injury. If disabled beyond the COP period, or if you are not entitled to COP, you may claim compensation on form CA-7 or use leave. If disabled due to occupational disease, you may claim compensation on form CA-7 or use leave. A claim for compensation for disability should be submitted as soon as possible after it is apparent that you are disabled and will enter a leave-without-pay status.

The Federal Employees' Compensation Act (FECA) is administered by the U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs (OWCP). Benefits include continuation of pay for traumatic injuries, compensation for wage loss, medical care and other assistance for job-related injury or death. For additional information about the FECA, read pamphlet CA-11, "When Injured at Work" of Federal Personnel Manual, Chapter 810, Injury Compensation, available from your employing agency. The agency will also give you the address of the OWCP Office which services your area.

Post on Employees' Bulletin Board

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

Form CA-10
Rev. Aug. 1987

OWCP Form CA-11

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Information Guide for Federal Employees

Introduction

The Federal Employees' Compensation Act (FECA) (5 U.S.C. 8101 et seq.) is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor. It provides compensation benefits to civilian employees of the United States for disability due to personal injury sustained while in the performance of duty or to employment-related disease. The FECA also provides for the payment of benefits to dependents if the injury or disease causes the employee's death. Benefits cannot be paid if the injury or death is caused by the willful misconduct of the employee or by the employee's intention to bring about his or her injury or death or that of another. (Intoxication (by alcohol or drugs) is the proximate cause of the injury or death.)

Medical Benefits

An employee is entitled to medical, surgical and hospital services and supplies needed for treatment of an injury as well as transportation for obtaining care. The injured employee has initial choice of physician and may select any qualified local physician or hospital to provide necessary treatment or may use agency medical facilities if available. Except for referral by the attending physician, any change in treating physician after the initial choice must be authorized by OWCP. Otherwise, OWCP will not be liable for the expenses of treatment.

The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists and chiropractors within the scope of their practice as defined by State law. Payment for chiropractic services is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist. If the physician selected has been excluded from participating in

OWCP Form CA-11 (continued)

the Compensation Program the OWCP District Office will advise the employee of the exclusion and the need to select another physician

Compensation for Temporary Total Disability

An employee who sustains a disabling, job-related traumatic injury may request continuation of regular pay for the period of disability not to exceed 45 calendar days or sick or annual leave If disability continues beyond 45 days or the employee is not entitled to continuation of pay, the employee may use sick or annual leave or enter a leave without pay status and claim compensation from OWCP

When disability results from an occupational disease, the employing agency is not authorized to continue the employee's pay The employee may use sick or annual leave or enter a leave without pay status and claim compensation

Compensation for loss of wages may not be paid until after a three-day waiting period, except when permanent effects result from the injury or where the disability causing wage loss exceeds 14 calendar days Compensation is generally paid at the rate of 2/3 of the salary if the employee has no dependents and 3/4 of the salary if one or more dependents are claimed

The term 'dependent' includes a husband, wife unmarried child under 18 years of age and a wholly dependent parent An unmarried child may qualify as a dependent after reaching the age of 18 if incapable of self-support by reason of mental or physical disability, or as long as the child continues to be a full-time student at an accredited institution, until he or she reaches the age of 23 or has completed four years of education beyond the high school level.

Compensation for Permanent Effects of Injury

The Act provides a schedule of benefits for permanent impairment of certain members, functions and organs of the body such as the eye, arm, or

kidney and for serious disfigurement of the head, face or neck For example, an award of 160 weeks of compensation is payable for total loss of vision in one eye

In addition, compensation for loss of earning capacity may be paid if the employee is unable to resume regular work because of injury related disability This compensation is paid on the basis of the difference between the employee's capacity to earn wages after an injury and the wages of the job he or she held when injured.

OWCP may arrange for vocational rehabilitation and provide a maintenance allowance not to exceed $200 per month A disabled employee participating in an OWCP-approved training or vocational rehabilitation program is paid at the compensation rate for total disability

If the employee's condition requires a constant attendant, an additional amount not to exceed $1500 per month may be allowed

Compensation for Death

If no child is eligible for benefits, the widow or widower's compensation is 50 percent of the employee's pay at the time of death, if death was due to the employment-related injury or disease. If a child or children are eligible for benefits, the widow or widower is entitled to 45 percent of the pay and each child is entitled to 15 percent. If children are the sole survivors, 40 percent is paid for the first child and 15 percent for each additional child, to be shared equally Other persons such as dependent parents, brothers sisters, grandparents, and grandchildren may also be entitled to benefits The total compensation may not exceed 75 percent of the employee's pay or the pay of the highest step for GS-15 of the General Schedule except when such excess is created by authorized cost-of-living increases.

Compensation to an employee's surviving spouse terminates upon his or her death or remarriage A widow or widower's benefits continue however, if the remarriage takes place after the age of 55 Awards to children brothers, sisters and grand-

OWCP Form CA-11 (continued)

children terminate at the age of 18, unless the dependent is incapable of self support, or continues to be a full-time student at an accredited institution until he or she reaches the age of 23 or has completed four years of education beyond the high school level.

Burial expenses not to exceed $800 are payable. Transportation of the body to the employee's former residence in the United States is provided where death occurs away from the employee's home station. In addition to any burial expenses or transportation costs, a $800 allowance is paid for the administrative costs of terminating an employee's status with the Federal Government.

Cost-of-Living Increases

Compensation payments on account of a disability or death which occurred more than one year before March 1 of each year are increased on that date by any percentage change in the Consumer Price Index published for December of the preceding year.

Settlements With Third Parties

Where an employee's injury or death in the performance of duty occurs under circumstances placing a legal liability on a party other than the United States, a portion of the cost of compensation and other benefits paid by OWCP must be refunded from any settlement obtained. OWCP will assist in obtaining the settlement and the Act guarantees that the employee may retain a certain proportion of the settlement (after any attorney fees and costs are deducted) even when the cost of compensation and other benefits exceeds the amount of the settlement.

Appeal Rights

An employee or survivor who disagrees with a final determination of OWCP may request an oral hearing or a review of the written record from the Branch of Hearings and Review. Oral and/or written evidence in further support of the claim may be presented. The employee may also request a

reconsideration of a decision by submitting a written request to the District Office which issued the decision. The request must be accompanied by evidence not previously submitted. If reconsideration has been requested, a hearing on the same issue may not be granted. The employee or survivor may also request review by the Employees' Compensation Appeals Board (ECAB). Because the ECAB rules solely on the evidence of record at the time the decision was issued, no additional evidence may be presented.

More Detailed Information

More detailed information about the requirements for coverage and benefits under the Federal Employees' Compensation Act may be obtained from Federal Personnel Manual Chapter 810, Injury Compensation, and booklet CA-550, Questions and Answers About the Federal Employees' Compensation Act, which answers questions commonly asked about compensation benefits. These publications may be obtained through your employing agency's personnel office.

What To Do...

1. ***Keep This Pamphlet.*** It is important that you know what you are entitled to, since benefits are not paid automatically. You or your survivors must claim them.

2. ***In Case of Injury,*** obtain first aid or medical treatment even if the injury is minor. While many minor injuries heal without treatment, a few result in serious prolonged disability that could have been prevented had the employee received treatment when the injury occurred.

For traumatic injuries, ask your employer to authorize medical treatment on Form CA-16 BEFORE you go to the doctor. Take Form CA-16 when you go to the doctor along with Form OWCP-1500 which the doctor must use to submit bills to OWCP. Your employer may authorize medical treatment for occupational disease ONLY if OWCP gives prior approval.

OWCP Form CA-11 (continued)

Submit bills promptly, as bills for medical treatment may not be paid if submitted to OWCP more than one year after the calendar year in which you received the treatment or in which the condition was accepted as compensable.

3. ***Report Every Injury*** to your supervisor. Submit written notice of your injury on Form CA-1 if you sustained a traumatic injury, or Form CA-2 if the injury was an occupational disease or illness. (Forms CA-1 and CA-2 may be obtained from your employing agency or OWCP.)

Form CA-1 must be filed within 30 days of the date of injury to receive continuation of pay (COP) for a disabling traumatic injury. COP may be terminated if medical evidence of the injury-related disability is not submitted to your employer within 10 workdays. YOU ARE RESPONSIBLE FOR ENSURING THAT SUCH MEDICAL EVIDENCE IS SUBMITTED TO YOUR EMPLOYING AGENCY. Form CA-2 should also be filed within 30 days. Any claim which is not submitted within 3 years will be barred by statutory time limitations unless the immediate superior had actual knowledge of the injury or death within 30 days of occurrence.

4. ***Establish the Essential Elements of Your Claim.*** You must provide the evidence needed to show that you filed for benefits in a timely manner, that you are a civil employee; that the injury occurred as reported and in the performance of duty; and that your condition or disability is related to the injury or factors of your Federal employment. OWCP will assist you in meeting this responsibility, which is called burden of proof, by requesting evidence needed to fulfill the requirements of your claim.

5. ***File a Claim for Compensation.*** File Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease, if you cannot return to work because of your injury and you are losing (or expect to lose) pay for more than three days. Give the form to your supervisor seven to ten days before the end of the COP period, if you received COP. If you are not entitled to COP, submit Form CA-7 when you enter or expect to enter a leave without pay status. All

wage loss claims must be supported by medical evidence of injury-related disability for the period of the claim.

If you continue to lose pay after the dates claimed on Form CA-7, submit Forms CA-8, Claim for Continuing Compensation on Account of Disability, through your employer to claim additional compensation until you return to work or until OWCP advises they are no longer needed. You are not required to use your sick or annual leave before you claim compensation.

If you choose to use your leave, you may, with your agency's concurrence, request leave buy back by submitting Form CA-7 to OWCP through your employing agency. Any compensation payment is to be used to partially reimburse your agency for the leave pay. You must also arrange to pay your agency the difference between the leave pay based on your full salary and the compensation payment that was paid at 2/3 or 3/4 of your salary. Your agency will then reredit the leave to your leave record.

6. ***Return To Work As Soon As your Doctor Allows You To Do So.*** If your employing agency gives you a written description of a light duty job, you must provide a copy to your doctor and ask if and when you can perform the duties described. If your agency is willing to provide light work, you must ask your doctor to specify your work restrictions. In either case, you must advise your agency immediately of your doctor's instructions concerning return to work, and arrange for your agency to receive written verification of this information. COP or compensation may be terminated if you refuse work which is within your medical restrictions without good cause, or if you do not respond within specified time limits to a job offer from your agency.

In appropriate cases, OWCP provides assistance in arranging for reassignment to lighter duties in cooperation with the employing agency. In addition, injured employees have certain other specified rights under the jurisdiction of the Office of Personnel Management, such as reemployment rights if the disability has been overcome within one year.

OWCP Form CA-11 (continued)

7. ***Tell Your Family*** about the benefits they are entitled to in the event of your death. For assistance in filing a claim they may contact your employing agency's personnel office or OWCP.

For Additional Information or When In Doubt About Your Compensation Benefits Write to the Office of Workers' Compensation Programs.

(Obtain the address of the OWCP district office from your employing agency.)

GPO : 1993 O - 355-962 QL 3

8

OWCP Form CA-13

NOTICE TO EMPLOYEE

The attached card provides instructions for you and your family in the event of your injury or death as a result of your employment.

Detach the card and keep it in your wallet for reference. It is important that you and your dependents know what to do in order to receive FECA benefits.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)
Washington, D.C. 20210

WORK INJURY BENEFITS FOR FEDERAL EMPLOYEES

If you sustain an injury which includes occupational disease or damage to medical appliances (eyeglasses, hearing aids, or other prosthetic devices) you may be entitled to benefits in the Federal Employees' Compensation Act (FECA).

WHEN INJURED

1. Notify your supervisor immediately and obtain authorization for medical care.
2. If necessary, report to your supervisor or someone acting on your behalf must complete the employer's portion of Form CA-1 and return it to your employing agency within 10 days of the injury. Use Form CA-2, if disability results from an occupational disease.

(CA-1 may be used if filed within 3 years following the injury.)

Form CA-13
Rev. July 1997

For more detailed information, carefully read the sheets which are attached to Forms CA-1 and CA-2.

3. If disabled due to traumatic injury, you may use Form CA-1 to claim continuation of pay. Form is filed within 45 days. Thereafter, compensation is claimed on Form CA-7. If disabled due to occupational disease, you may use these forms to claim compensation on Form CA-7.

DEATH BENEFITS

Compensation may also be payable to certain members of your family if job-injured death. A claim for death benefits must be filed with your agency or the OWCP promptly. Death benefits may also be available from your agency or the OWCP.

For additional information about the FECA, request Publication CA-11 (Injury Compensation for Work Injuries) (Rev. 7-93) available from your agency. The Agency will assign you the necessary forms and the address of the OWCP office which serves your area.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)
Washington, D.C. 20210

INSTRUCTIONS TO FEDERAL AGENCIES

1. Issue this card to each employee of your agency.
2. Further information regarding the Federal Employees Compensation Act (FECA) may be obtained from the OWCP and/or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.
3. Additional cards may be obtained from the OWCP office servicing your area.

Form CA-13
Rev. July 1997

OWCP Form CA-16 Instructions

Authorization for Examination and/or Treatment

Summary

Purpose

Authorization for an employee to obtain medical care or treatment from a doctor or medical facility of his or her choice following an injury or illness.

Timeliness

Following a traumatic injury which does not require emergency care, the form must be issued within four hours after the injury or after request for medical care by the injured employee.

The form may be issued for an occupational illness or disease; however, it cannot be issued without the permission of the OWCP district office — a claims examiner or higher level OWCP person.

When a traumatic injury requires emergency care, and a CA-16 cannot be provided at the time of the care, it will be issued to the source of emergency care within 48 hours.

When to Prepare

Prepare this form at the following time:

a. Following a traumatic injury which requires medical care.

b. *At the discretion of the control office,* it *may* be issued following a recurrence if it is either within six months after the injury, within six months after the last medical care, or within six months after the return to work from the first period of disability *(this is a very rare situation).*

When Not to Prepare

a. Following the submission of an occupational claim (CA-2) *unless authorized by the OWCP district office.*

b. Following a heart attack, the employee or representative may file a CA-2 if they believe that the heart attack arose out of and in the course of their job.

c. Following a recurrence if it is more than six months after the injury or after the return to work from the *first* period of disability.

d. Should not be used to authorize a change of physicians after the initial choice has been made.

e. An employee may not execute a CA-16 in his or her own behalf.

OWCP Form CA-16 Instructions (continued)

f. When an injured employee is seen or treated by either a postal medical officer or contract doctor for a first aid case not reportable to OWCP district office

Who Prepares

a. Authorized control office personnel.

b. Trained and authorized control point personnel. Medical or Health unit medical personnel (if applicable) and authorized control points. Authorizing office *must* be supervisory level.

General Procedures

The authorized official will complete the CA-16 in triplicate. The original and one copy will be sent with the employee to the treating physician along with a pre-addressed envelope.

The physician will complete part B of the form and should be requested to either give the copy to the employee for immediate return to the control office/point, or mail it to the control office in the envelope provided.

Filing and Distribution

Filing and distribution procedures as follows:

a. Send the original to the OWCP district office.

b. Copy to claimant's Injury Compensation file.

Instructions

Part A – Authorization will be completed by the issuing, authorized official.

1. *After an appointment has been made*, enter the name and address of the physician or hospital selected by the employee. If issued for emergency care, indicate "*emergency care,*" and enter the name and address of the source of such care.

   Note: If issued for a recurrence, the source of medical care should be the same as the previous authorization.

2. Claimant's complete name; last name, first name, and middle name (Enter "NMN" if no middle name).

3. Date of injury per Items 10 and 21 on the CA-1; or, Item 29, on the CA-2.

4. Enter the employee's craft or title and either FTRS, PTRS, Casual, Transitional Employee, EAS, PCES, or other.

5. *Provide a description of the injury or part of the body affected*. Be specific, this information may assist the doctor.

OWCP Form CA-16 Instructions (continued)

Note: It is permissible to add a stamped or typed statement such as *Limited duty may be available, in accordance with the attached job or function description.*

6. a. Check box 6.B.1. if there is *no doubt* as to the validity of the injury.

   b. Check box 6.B.2. if there IS ANY DOUBT concerning the relationship of the injury to the employee's work, or any doubt that an injury occurred.

   c. If the form is issued for an occupational claim, check 6.B.2.

7. Complete if the form is issued for an occupational illness or disease. Insert name and title of approving OWCP official, a claims examiner, or higher level OWCP person.

8. Authorized official's signature.

9. Self-explanatory.

10. Commercial telephone number.

11. Date of issue.

12. Complete, but request return of the copy to the ICCO.

13. Complete with mailing address of the ICCO.

OWCP Form CA-16

Authorization for Examination And/Or Treatment

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

The following request for information is authorized by law (5 USC 8101 et seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under the 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 Circ. No. A-108.

OMB No. 1215-0101
Expires 10-31-94

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service

2. Employee's Name (last, first, middle)

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 either 1 or 2, in item B.

A. Your signature in item 15 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.

B. ☐ 1. Furnish all medical 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 standard 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 due 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. Signature of Authorizing Official:

9. Name and Title of Authorizing Official (Type or print clearly)

10. Local Employing Agency Telephone Number

11. Date (mo., day, year)

12. Send one copy of your report (Fill in remainder of address)

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

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

Department or Agency

Bureau or Office

Local Address (including ZIP Code)

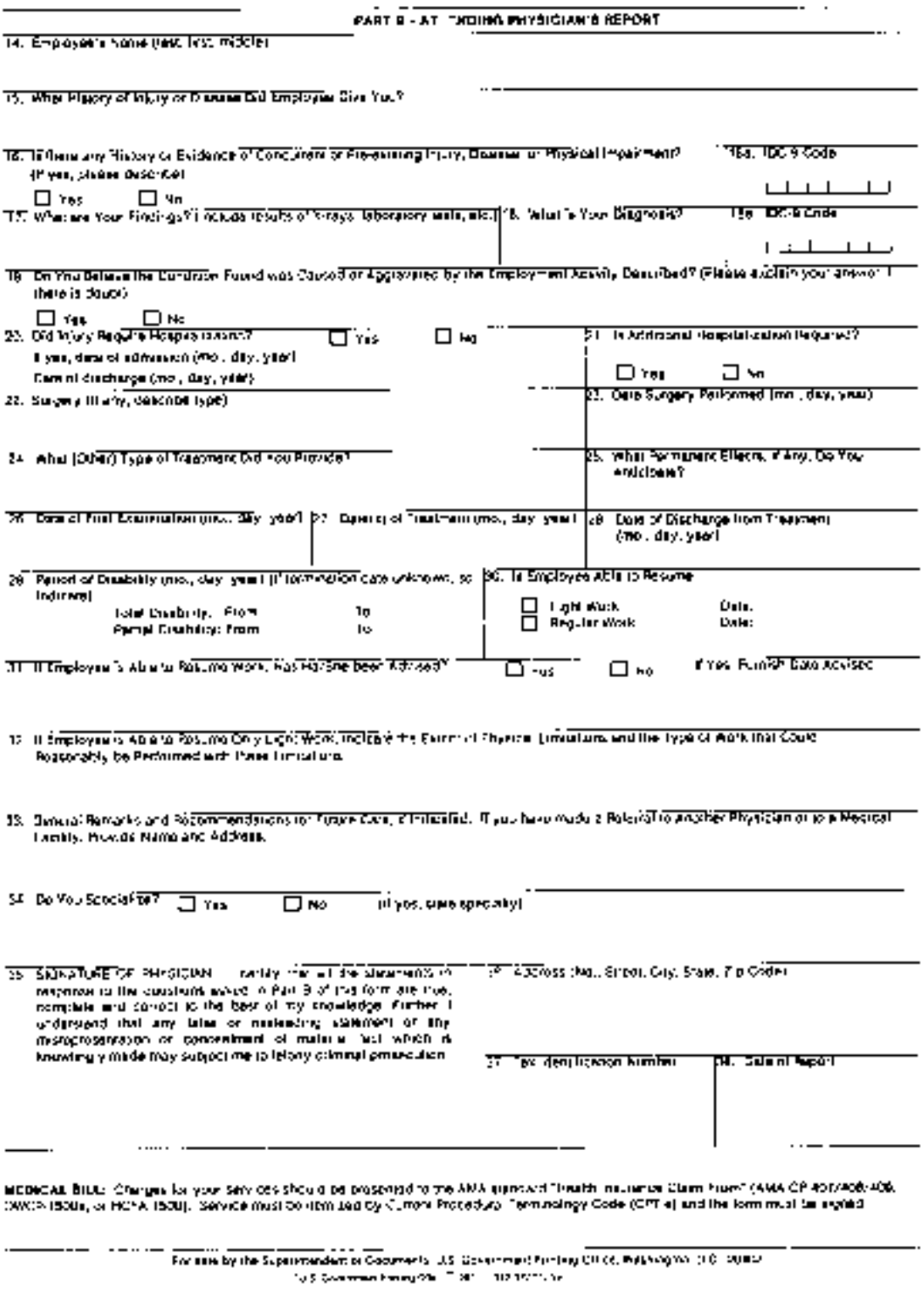
Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, 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 these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Risk Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0101), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Form CA-16
Rev. Oct. 1989

OWCP Form CA-16 (continued)



PART B - ATTENDING PHYSICIAN'S REPORT

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

15. What History of Injury or Disease Did Employee Give You?

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

16a. ICD-9 Code

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

18. What is Your Diagnosis?

18a. ICD-9 Code

19. Do You Believe the Condition 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? ☐ Yes ☐ No

If yes, date of admission (mo., day, year)

Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required? ☐ Yes ☐ No

22. Surgery (If any, describe type)

22. 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 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 Exertional Physical Limitations and the Type of Work that Could Reasonably be Performed with These Limitations

33. Clinical 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. SIGNATURE OF PHYSICIAN I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

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

37. Tax Identification Number

38. Date of Report

MEDICAL BILL: Charges for your services should be presented on the AMA approved Health Insurance Claim Form (AMA CP-4/CP-4/CP-4/CP-4, OWCP-1500a, or HCFA 1500). Services must be identified by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
U.S. Government Printing Office: [illegible]

OWCP Form CA-16 (continued)

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician or facility of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or duly qualified physician/hospital of the employee's choice.

  If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA CPT A01/A06/A08, OWCP 1500) should be supplied together with Form CA-16.

  A physician who is debarred from the FECA program as provided at 20 CFR 10.450 et seq. may not be authorized to treat/refer or provide an injured Federal employee.

  Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance and may be terminated earlier upon written notice from OWCP to the physician. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, military, or VA hospitals. Federal health service facilities (health units established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, x-rays and laboratory tests and x-rays to diagnose a subluxation of the spine, and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in item 1 and the signature of the authorizing official appears in item 8. Check B1 or B2 of item 8, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

  Show the address of the proper OWCP Office in item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Chapter 2-0, Federal Personnel Manual (FPM).

Information for Physician - See Reverse Side

OWCP Form CA-16 (continued)

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in item 6, for a period of not more than 90 days from the date of issuance, subject to the conditions in item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-465 may not be authorized to examine or treat an injured federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 90 day period, apply to the office shown in Part A, item 12.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided in a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 35, of Part B, and send your report, together with any additional narrative or supplementary material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17, "Duty Status Report" may be secured by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA CPT 4(1/4/95/4/96; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 D of the form, by the applicable Current Procedural Terminology (4th edition) Code (CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. Eligible providers should decide on a single TIN, either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

OWCP Form CA-17 Instructions

Summary

Purpose

To keep the ICCO and the OWCP office informed of the injured or ill employee's ability to return to either limited or full duty.

Prepared By

1. SIDE A.
   a. For initial disability: direct supervisor.
   b. For continuing full or partial disability: ICCO
2. SIDE B: Treating Physician

When to Prepare

1. After initial injury to accompany the CA-16.
2. For continuing total disability for each medical visit; or at a minimum of each two weeks.
3. For continuing limited duty or follow up examinations when employee has returned to duty.

General Procedures

1. The appropriate official completes Side A
2. The employee delivers this form, along with the CA-16, job descriptions, and OWCP Form 1500 as appropriate, to the treating physician.
3. The treating physician will complete Side B of the form and either give it, along with the approved job descriptions, to the employee for immediate return to the ICCO or, if necessary, mail to the ICCO in the envelope provided.

Filing and Distribution

Filing and distribution procedures are as follows:

1. ICCO will forward the *original* of the form to OWCP (**Note**: the form instructions state to send a copy to OWCP, however the USPS policy is to send the original CA-17 to OWCP)
2. Keep a *copy* in the Injury Compensation file.

OWCP Form CA-17 Instructions (continued)

Instructions

Side A is to be completed by the immediate supervisor/control office/point.

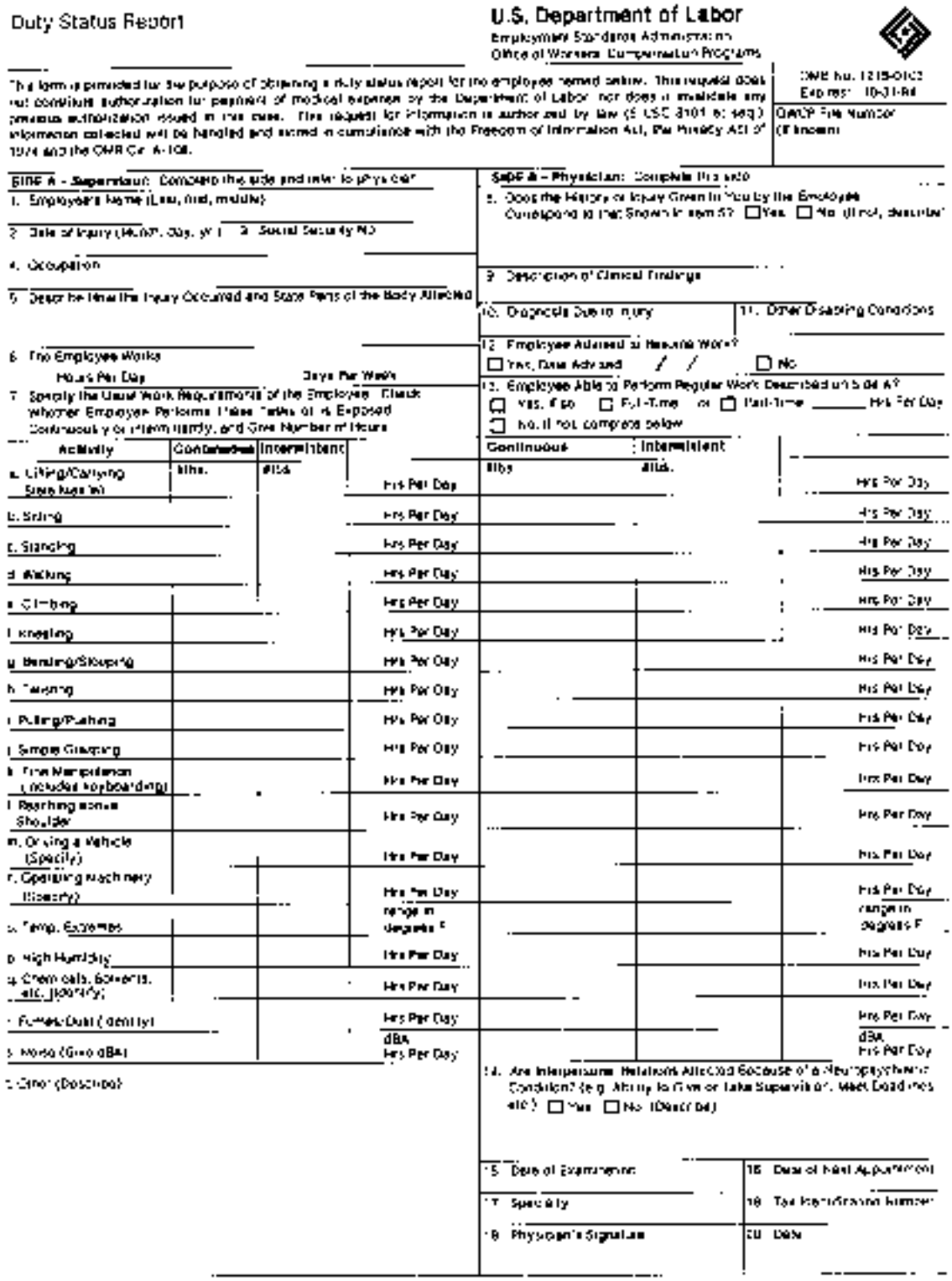
1. Claimant's complete name; last name, first name, and middle name.

   (Enter "NMN" if no middle name)

2. Date of injury; Item 10 or 21 on the CA-1 or Item 29 on the CA-2.
3. SSN consists of NINE digits.
4. Occupation (employee's title).
5. Brief description of injury or illness and part(s) of body affected. Refer to Item 13 and 14 on the CA-1 or Item 14 on the CA-2.
6. Work schedule
7. Complete as accurately as possible based on the work the employee *actually* performs in his or her *regular assignment.*

   Note: The attending physician completes Side B. A physician's assistant, nurse practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. Certification by a physician's assistant will be acceptable if such certification is countersigned by a physician.

OWCP Form CA-17



Duty Status Report

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

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expenses by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.). Information collected will be handled and stored in accordance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Circular A-108.

OMB No. 1215-0162
Expires: 10-31-96

OWCP File Number (If known)

PART A – Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)
2. Date of Injury (Month, Day, Year) 3. Social Security No.
4. Occupation
5. Describe How the Injury Occurred and State Parts of the Body Affected
6. The Employee Works ____ Hours Per Day ____ Days Per Week
7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs Listed Tasks or Is Exposed Continuously or Intermittently, and Give Number of Hours

Activity	Continuous	Intermittent	
a. Lifting/Carrying (See Note W)	Wts.	Wts.	Hrs Per Day
b. Sitting			Hrs Per Day
c. Standing			Hrs Per Day
d. Walking			Hrs Per Day
e. Climbing			Hrs Per Day
f. Kneeling			Hrs Per Day
g. Bending/Stooping			Hrs Per Day
h. Twisting			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day
j. Simple Grasping			Hrs Per Day
k. Fine Manipulation (Includes Keyboarding)			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day
o. Temp. Extremes			range in degrees F
p. High Humidity			Hrs Per Day
q. Chemicals, Solvents, etc. (Specify)			Hrs Per Day
r. Fumes/Dust (Identify)			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day

t. Other (Describe)

PART B – Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)
9. Description of Clinical Findings
10. Diagnosis Due to Injury
11. Other Disabling Conditions
12. Employee Advised to Resume Work? ☐ Yes, Date Advised ___/___/___ ☐ No
13. Employee Able to Perform Regular Work Described in 5 of A? ☐ Yes, If so ☐ Full-Time or ☐ Part-Time ____ Hrs Per Day ☐ No, If not, complete below

Continuous	Intermittent	
Wts.	Wts.	
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		range in degrees F
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination
16. Date of Next Appointment
17. Specialty
18. Tax Identification Number
19. Physician's Signature
20. Date

OWCP Form CA-17 (continued)

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, 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 of this collection of information, including suggestions for reducing this burden, send them to the Office of the Policy, U.S. Department of Labor, Room N-3201, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and to the Office of Management and Budget, Paperwork Reduction Project (1215-0123), Washington, D.C. 20503

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Form CA-17
Rev. July 1991

Printed by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

OWCP Form CA-20 Instructions

Attending Physician's Report

Summary

Purpose

Medical report to support an injury or illness claim. May be used in occupational disease cases for follow-up reports.

Who Prepares

a. Items 1–3 completed by the employee (see CA-20 instructions on the CA-7.)

b. Items 4–32 completed by the treating physician.

When to Prepare

a. When the CA-7 or CA-8 is submitted.

b. At intervals to be determined by ICCO.

Filing and Distribution

Filing and distributing procedures are as follows:

a. Original to the OWCP.

b. Copy to claimant's injury compensation file.

Instructions

a. Items 1–3 should be completed by the employee.

b. Items 4–32 should be completed by the attending physician; however, either a narrative report or another form may be acceptable.

Note: A physician's assistant, nurse practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. Certification by a physician's assistant will be acceptable if such certification is countersigned by a physician. Rubber stamp signatures are not acceptable.

c. On receipt of the completed form from the physician, the ICCO should review it to ensure that the history of injury in Item 5 is consistent with the original claim; refer to Items 13 and 14 on the CA-1 or to Items 11–14 on the CA-2.

d. If a conflict is discovered, making allowance for terminology, typographical errors, and memory lapses, the claim should be evaluated for controversion.

e. The remainder of the physician's report should be checked for completeness. Pay particular attention to the periods of total and partial disability to

OWCP Form CA-20 Instructions (continued)

authorize COP/LWOP-IOD, and to return the employee to limited duty or full duty at the earliest possible time.

In the event the physician forwards the CA-20, or an acceptable narrative report directly to the OWCP, a copy of the same should be requested from either the OWCP or from the employee. Remember, LWOP-IOD (Code 49) should not be entered into the timekeeping system without supporting medical evidence.

OWCP Form CA-20

Attending Physician's Report

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

Record of Examination

1. Patient's name — Last — First — Middle
2. Date of Injury — mo. day yr.
3. OWCP File Number
OMB No. 1215-0170
Expires: 9-30-98

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of congenital or preexisting injury or disease or physical impairment? (If yes, please describe)
☐ Yes ☐ No
ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis?
ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer)
☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item 13.
☐ Yes ☐ No
10. Date of admission — mo. day yr.
11. Date of discharge — mo. day yr.
12. Additional hospitalization required? If Yes, describe in "Remarks" (item 25)
☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination — mo. day yr.
15. Date(s) of treatment — mo. day yr. — mo. day yr. — mo. day yr.
16. Date of discharge from treatment — mo. day yr.

17. Period of total disability — From mo. day yr. Thru mo. day yr.
18. Period of Partial Disability — From mo. day yr. Thru mo. day yr.
19. Date employee able to resume light work — mo. day yr.

20. Date employee able to resume regular work — mo. day yr.
21. Has employee been advised that he/she can return to work?
☐ Yes ☐ No
22. If yes, on what date was he/she advised? — mo. day yr.

23. 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. (Continue on item 25 if necessary.)
24. Are any permanent effects expected as a result of this injury? If yes, describe in item 25.
☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City — State — Zip
Specialty
27. What was the reason for the referral?
☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to federal criminal prosecution.

Signature of Physician — Date

29. Name of Physician
30. Tax ID number

Address
31. Do you specialize?
☐ Yes ☐ No
City — State — Zip
32. If yes, what is your specialty

Form CA-20
Rev. June 1990

OWCP Form CA-20 (continued)

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-12 ON THE FORM, AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 11, AND
3. SEND THE FORM AND YOUR BILL TO

OFFICE OF WORKERS' COMPENSATION PROGRAMS

Public Burden Statement

We estimate that it will take an average of 20 minutes to complete this collection of information, 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 these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of DM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210, and to the Office of Management and Budget, Paperwork Reduction Project (1215-0101), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

OWCP Form CA-20 (continued)

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should attach Form CA-20 complete items 1-3 on the front, and mail the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 in order to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for routine statistics, and computer matching of benefit and payment files.)

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION

OWCP Form CA-20a Instructions

Attending Physician's Supplemental Report

Summary

Purpose

Medical report to support continuing, total disability.

Who Prepares

a. Items 1–6 by the employee (see employee instructions on CA-8).

b. Items 7–23 by the treating physician.

When to Prepare

If medical report is required, each time a CA-8 is submitted.

Filing and Distribution

For filing and distributing, do the following:

a. Send an original to the OWCP.

b. Send a copy to claimant's injury compensation file.

Instructions

a. Items 1–6 should be completed by the employee.

b. Items 7–23 should be completed by the attending physician; however, either a narrative report or another form may be acceptable. See physician's instructions on the following page.

Note: A physician's assistant, nurse practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. Certification by a physician's assistant will be acceptable if such certification is countersigned by a physician. Rubber stamp signatures are not acceptable.

c. On receipt of the completed form from the physician, the CO should review it to ensure that the impairment described in Item 10 is consistent with the original injury/claim or medical history.

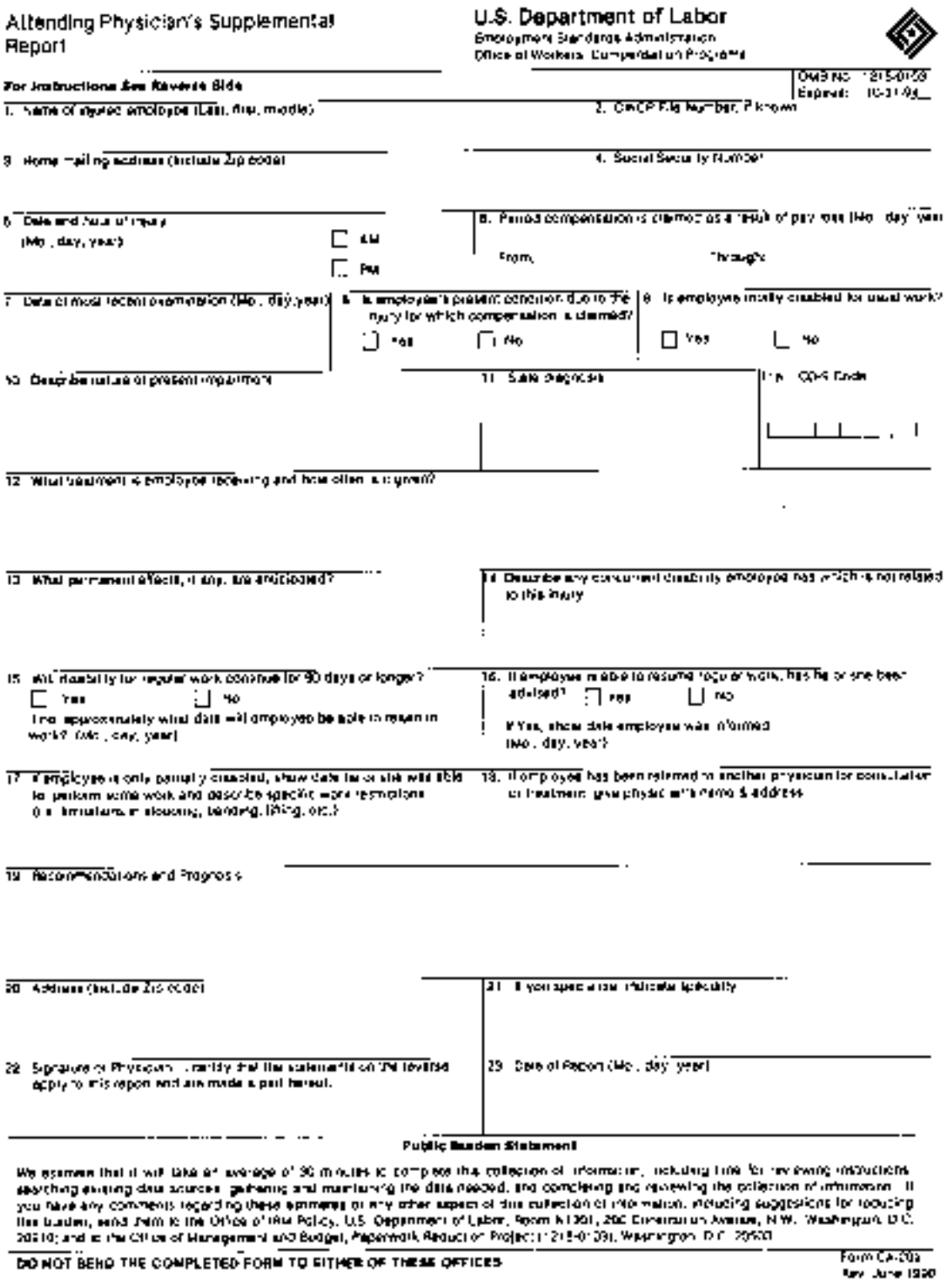
d. If a conflict is discovered, making allowance for terminology, typographical errors, and memory lapses, the claim should be evaluated for controversion.

e. The remainder of the form/report should be checked for completeness and consistency with earlier reports. Particular attention should be made to the periods of total and partial disability or authorize LWOP-IOD, and to return the employee to limited duty or full duty at the earliest possible time.

OWCP Form CA-20a Instructions (continued)

In the event the physician forwards the CA-20a, or an acceptable narrative report directly to the OWCP, a copy of same should be requested from the OWCP or from the employee. Remember, LWOP-IOD (code 49) should not be entered into the timekeeping system without supporting medical documentation.

OWCP Form CA-20a



Attending Physician's Supplemental Report

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

For Instructions See Reverse Side

OMB NO. 1215-0170
Expires: 10-31-95

1. Name of injured employee (Last, first, middle)
2. OWCP File Number, If known
3. Home mailing address (Include Zip code)
4. Social Security Number
5. Date and hour of injury (Mo., day, year) AM PM
6. Period compensation is claimed as a result of pay loss (Mo., day, year) From: Through:
7. Date of most recent examination (Mo., day, year)
8. Is employee's present condition due to the injury for which compensation is claimed? Yes No
9. Is employee totally disabled for usual work? Yes No
10. Describe nature of present impairment
11. State Diagnosis
11a. ICD-9 Code
12. What treatment is employee receiving and how often is it given?
13. What permanent effects, if any, are anticipated?
14. Describe any concurrent disability employee has which is not related to this injury
15. Will disability for regular work continue for 90 days or longer? Yes No
If so, approximately what date will employee be able to return to work? (Mo., day, year)
16. If employee is able to resume regular work, has he or she been advised? Yes No
If Yes, show date employee was informed (Mo., day, year)
17. If employee is only partially disabled, show date he or she will be able to perform some work and describe specific work restrictions (i.e. limitations on sitting, bending, lifting, etc.)
18. If employee has been referred to another physician for consultation or treatment, give physician's name & address
19. Recommendations and Prognosis
20. Address (Include Zip code)
21. If you specialize, indicate specialty
22. Signature of Physician - I certify that the statements on the reverse apply to this report and are made a part hereof.
23. Date of Report (Mo., day, year)

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, 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 these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Risk Policy, U.S. Department of Labor, Room N-3301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0170), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

Form CA-20a
Rev. June 1990

OWCP Form CA-20a (continued)

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT:

A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20a.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM,. HCFA-1500/OWCP 1500a.

1. Complete the entries 7-23 on this report (and items 1-6 if not previously completed), and
2. Forward the report directly by mail to the OWCP office indicated below.
3. OFFICE OF WORKERS' COMPENSATION PROGRAMS

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in tracking matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10.10. (4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. Disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

U.S. Government Printing Office: 1980 — 341-123/00126

OWCP Form CA-35A

Evidence Required in Support of a Claim for Occupational Disease

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

All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job factors.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.	
4. Attach or forward a medical report from your physician to include the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.	

FROM EMPLOYING AGENCY	✓
5. Review and comment on employee's statement provided in response to item no. 1.	
6. If employee's job differs from official description, describe exactly his/her duties.	
7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Pertinent dispensary records. d. Most recent SF-50, Notification of Personnel Action.	

Form CA-35A
Rev. Aug 1988

OWCP Form CA-35A (continued)

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed to let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a postcard advising you of the case number. Use that number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist specifying evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well-rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35B

Evidence Required in Support of a
Claim for Work-Related Hearing Loss

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

IF YOU ARE FILING A CLAIM FOR HEARING LOSS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-7. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service.	
2. For each job title, describe source of noise, number of hours of exposure per day, and use of any safety devices to protect against noise exposure. State when safety devices were provided.	
3. Give history of any previous ear or hearing problems.	
4. Describe any hobbies which involve exposure to loud noise.	
5. If you are no longer exposed to hazardous noise at work, give the date you were last exposed.	
6. If you have been examined or treated by a doctor for an ear or hearing problem, provide a medical report and audiograms.	
7. State whether a claim for workers' compensation benefits for this or any other condition affecting ears or hearing was ever filed. If so, give date of claim, name and address where filed, and benefits received.	
8. Give the date you first noticed your hearing loss.	
Give date you first related hearing loss to employment, and reason why.	

FROM EMPLOYING AGENCY	✓
9. Review and comment on the employee's statement in response to questions 1-8.	
10. Describe all work-related exposure to hazardous noise, including: a. Locations of job sites. b. Nature of exposure to noise (machinery, etc.) c. Decibel and frequency level (noise survey report) for each job site. d. Period of exposure, hours per day, days per week. e. Type of ear protection provided.	
11. Attach copies of the employee's: a. SF-171, Application for Employment. b. Job sheet and employment record. c. All medical examinations pertaining to hearing or ear problems, including preemployment examination and all audiograms.	
12. If the employee is no longer exposed to hazardous noise, give date of last exposure and the payrate in effect on that date.	

Form CA-35B
Rev. Aug. 1988

OWCP Form CA-35B (continued)

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35C

Evidence Required in Support of A Claim for Asbestos-Related Illness

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

If you are filing a claim based on exposure to asbestos, use this checklist to identify the information needed from you and your employing agency. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE

1. List your employment history by employer, job title, and inclusive dates. Include non-Federal employment and military service. [see attached questionnaire.]

2. For each job title, describe the work you performed, the type of asbestos material used, locations where exposure occurred, period of exposure, number of hours per day and days per week exposed, and the types and frequency of safety precautions (mask, respirator, etc.) used. [see attached questionnaire].

3. Describe any exposure you have had to other toxic substances. If none, state "None".

4. Describe any breathing or lung problems you have had in the past and treatment received. [see attached questionnaire.]

5. Give your smoking history to include amount per day, and years (dates) you have smoked. [see attached questionnaire].

6. Submit a report from your physician including chest x-ray report, history, physical findings, diagnosis, opinion as to the relationship of the condition to employment, and course of treatment.

7. Give the date you first consulted a physician regarding this injury or asbestos-related disease.

8. Submit reports of examination, treatment or hospitalization for any previous similar condition or pulmonary problem.

FROM EMPLOYING AGENCY

9. Review and comment on the accuracy of the employee's description of work performed and exposure to asbestos and other substances.

10. Provide exposure data, including air sample surveys or estimates of the type of asbestos exposure, frequency, degree and duration for each job held. Air sample results should be reported in units of fibers/cc (f/cc) time weighted average. Also report concentrations of other pollutants and chemicals. [see attached questionnaire].

11. Give the date employee was last exposed to asbestos at work. If the employee was removed from exposure, give the circumstances.

12. Attach copies of the employee's

    a. SF-171 Application for Employment

    b. Position description with physical requirements for each job held

    c. Job sheet and employment record

    d. Pertinent dispensary records.

    e. Most recent SF-50, Notification of Personnel Action.

    f. Laboratory test results and chest x-ray reports on file

13. Describe safety regulations and protective devices in use by employee with period and frequency of use.

Form CA-35C
Oct. 1981

OWCP Form CA-35C (continued)

Notice to Employees Filing Claim for Occupational Disease

Diseases and illnesses which occur during or after federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 | "Federal Employee's Notice of Occupational Disease and Claim for Compensation" | your statements in response to the checklist and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or list as know when we can expect the information. Your supervisor and the Compensation Specialist will compile the administrative information required and forward a complete and organized package to OWCP. If your agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS. Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

Notice to Compensation Specialists and Supervisors

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

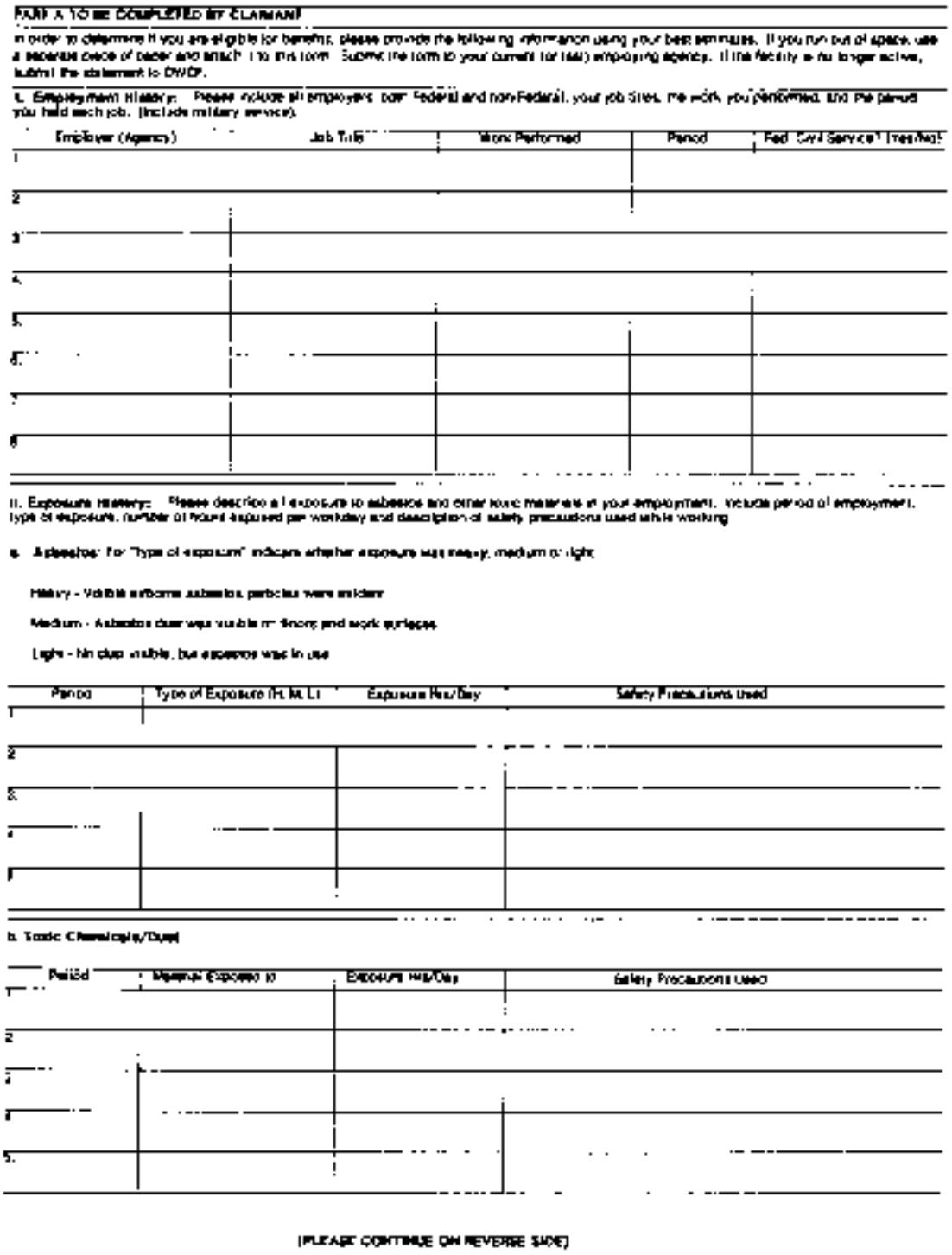
1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the complete package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35C (continued)



PART A TO BE COMPLETED BY CLAIMANT

In order to determine if you are eligible for benefits, please provide the following information using your best estimates. If you run out of space, use a separate piece of paper and attach it to this form. Submit the form to your current (or last) employing agency. If the facility is no longer active, submit the statement to OWCP.

I. Employment History: Please include all employers (both Federal and non-Federal), your job titles, the work you performed, and the period you held each job. (Include military service).

	Employer (Agency)	Job Title	Work Performed	Period	Fed. Civil Service? (Yes/No)?
1					
2					
3					
4					
5					
6					
7					
8					

II. Exposure History: Please describe all exposure to asbestos and other toxic materials at your employment. Include period of employment, type of exposure, number of hours exposed per workday and description of safety precautions used while working.

a. Asbestos: For "Type of exposure" indicate whether exposure was heavy, medium or light.

Heavy - Visible airborne asbestos particles were evident

Medium - Asbestos dust was visible on floors and work surfaces

Light - No dust visible, but asbestos was in use

	Period	Type of Exposure (H, M, L)?	Exposure Hrs/Day	Safety Precautions Used
1				
2				
3				
4				
5				

b. Toxic Chemicals/Dust

	Period	Material Exposed to	Exposure Hrs/Day	Safety Precautions Used
1				
2				
3				
4				
5				

(PLEASE CONTINUE ON REVERSE SIDE)

OWCP Form CA-35C (continued)

III. Medical History: Describe your medical history and include any treatment for heart, lung and other major health problems

Have you ever had	Yes	No	If "Yes" explain	Dates
1. Heart Problems?				
2. Lung Problems?				
3. Other Major Problems?				

IV. Smoking History: Describe your smoking history, including dates you smoked, amount of material smoked per day, and type of material smoked

Have you ever smoked	Yes	No	If Yes, amount	No. of years	Date stopped	Dates
1. Cigarettes?						
2. Pipe?						
3. Cigars?						

PART B TO BE COMPLETED BY EMPLOYING AGENCY

Using the categories shown below, please complete the chart at the bottom of the page with reference to each Federal job held by the employee

a. Nature of Exposure

Primary - Normal duties included actual manipulation of asbestos and/or asbestos-related products and generated dust.

Secondary - Normal duties regularly involved work alongside others primarily exposed or in confined spaces.

Maintenance - Normal duties regularly involved entry into locations where asbestos and/or asbestos products were manipulated.

Environmental - Normal duties were performed at a location where asbestos was used but the individual had no normal exposure to asbestos at significant levels.

b. Degree of Exposure

Heavy - Asbestos dust was visibly visible in the air.

Medium - Asbestos dust was generally visible on work surfaces but did not cloud the air.

Light - Asbestos was used in work area but was generally not visible (although detectable).

Ambient - Asbestos levels did not exceed normal levels in the air outside of work spaces.

c. Frequency of Exposure - Hours per day.

Job Title	Period		Asbestos Exposure			Other Chemical or Dust Exposure				
	From	To	Nature	Degree	Frequency	Material	Nature	Degree	Frequency	Fiber/cc
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										

OWCP Form CA-35D

Evidence Required in Support of a Claim for Work-Related Coronary/Vascular Condition

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

IF YOU ARE FILING A CLAIM FOR CORONARY OR VASCULAR CONDITIONS (for example heart attack, stroke, hypertension) THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed description of the factors of your employment you believe responsible for your condition. Identify dates, periods, events, people involved, etc.	
2. If you are claiming compensation for a heart attack or stroke, provide a specific account of your activities on and off duty for one week prior to the attack, with emphasis on the twenty-four hours immediately preceding the attack.	
3. If you have a prior history of heart problems, provide a description of your condition and copies of medical records of treatment.	
4. Give your smoking history to include amounts and years (dates) you smoked.	
5. Provide a medical report from your physician which includes:	
a. Dates of examination and treatment.	
b. History given by you.	
c. Family history and other risk factors.	
d. Detailed description of findings.	
e. Copies of all diagnostic test results.	
f. Diagnosis.	
g. The clinical course of treatment followed.	
h. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements in response to questions 1-5.	
7. Describe in detail the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
8. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
9. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
10. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
11. Attach copies of the employee's:	
a. SF-171, Application for Employment.	
b. Position description with physical requirements.	
c. Preemployment medical examination.	
d. All other pertinent medical reports available.	
e. Most recent SF-50, Notification of Personnel Action.	

Form CA-35D
Rev. Aug. 1988

OWCP Form CA-35D (continued)

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or arise Federal employment are not automatically covered by the Federal Employees' compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed to let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS. Are your statements legible. Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the promptness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

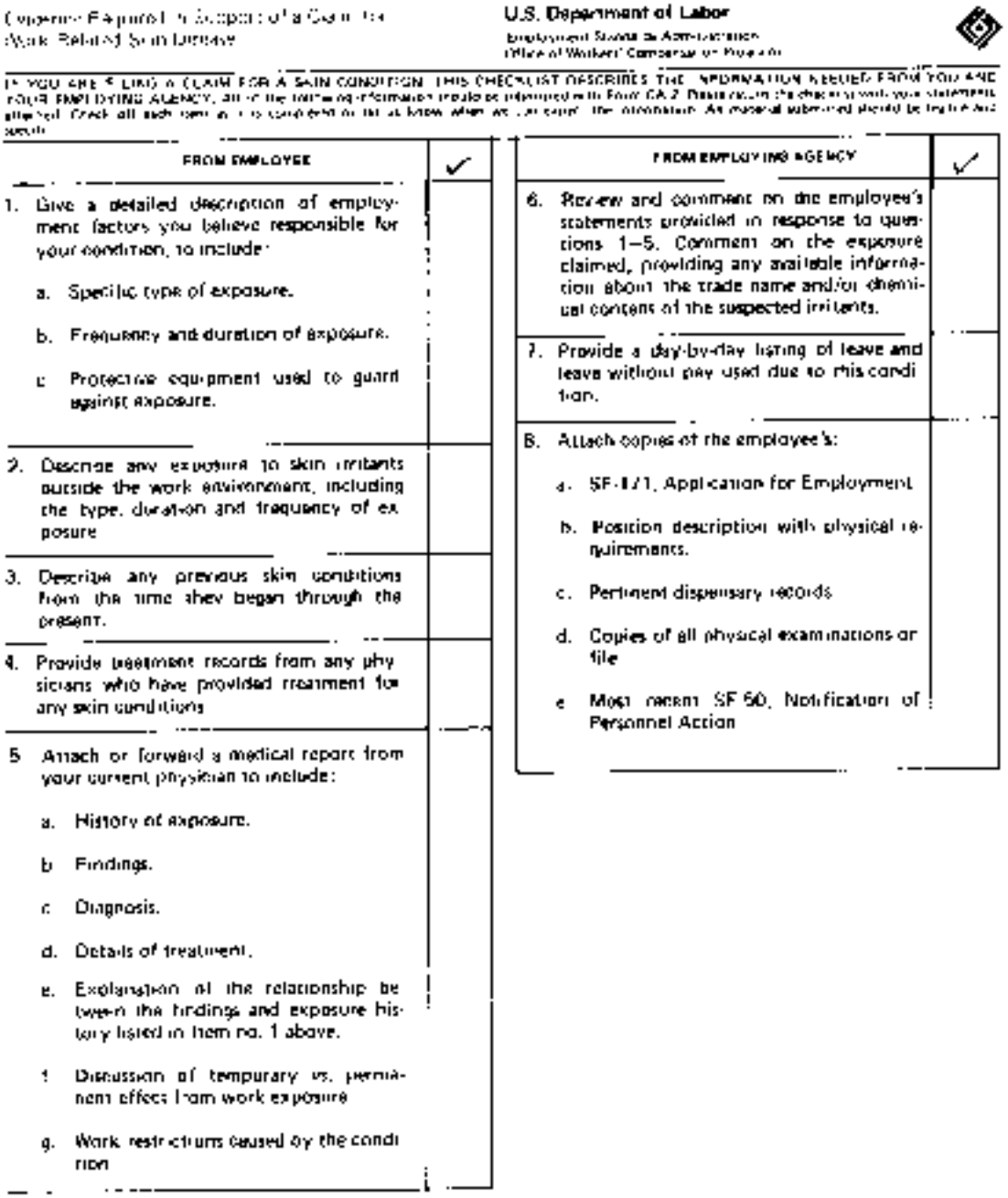
1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35E



Checklist to Accompany a Claim for Work Related Skin Disease

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

IF YOU ARE FILING A CLAIM FOR A SKIN CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All of the information listed is important to Form CA-2. Please review the checklist with your statement attached. Check all such items as it is completed or as it is known when we request the information. All material submitted should be typed and legible.

FROM EMPLOYEE	✓
1. Give a detailed description of employment factors you believe responsible for your condition, to include: a. Specific type of exposure. b. Frequency and duration of exposure. c. Protective equipment used to guard against exposure.	
2. Describe any exposure to skin irritants outside the work environment, including the type, duration and frequency of exposure	
3. Describe any previous skin conditions from the time they began through the present.	
4. Provide treatment records from any physicians who have provided treatment for any skin conditions	
5. Attach or forward a medical report from your current physician to include: a. History of exposure. b. Findings. c. Diagnosis. d. Details of treatment. e. Explanation of the relationship between the findings and exposure history listed in item no. 1 above. f. Discussion of temporary vs. permanent effect from work exposure g. Work restrictions caused by the condition	

FROM EMPLOYING AGENCY	✓
6. Review and comment on the employee's statements provided in response to questions 1–5. Comment on the exposure claimed, providing any available information about the trade name and/or chemical content of the suspected irritants.	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment b. Position description with physical requirements. c. Pertinent dispensary records d. Copies of all physical examinations on file e. Most recent SF 50, Notification of Personnel Action	

CA-35E
August 1992

OWCP Form CA-35E (continued)

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a post card advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS - Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the promptness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee signs on his or her claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and
2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35F

Evidence Required in Support of a Claim for Work-Related Pulmonary Illness (not asbestosis)

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

IF YOU ARE FILING A CLAIM FOR PULMONARY CONDITION NOT RELATED TO EXPOSURE TO ASBESTOS, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. As of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE	✓
1. Describe the work conditions which caused or aggravated your pulmonary condition; include types of irritants, dates of exposure and hours per day. Describe any safety measures taken.	
2. Explain the development of the present pulmonary condition and treatment from its beginning.	
3. Give your smoking history to include amounts and years (dates) you smoked.	
4. Give the history of previous pulmonary conditions; include dates and nature of illness, and treatment records from all physicians and hospitals where you were treated.	
5. Attach or forward a medical report which includes the following items: a. Dates of examination and treatment. b. History given by you. c. Detailed description of findings. d. Results of all diagnostic tests. e. Diagnosis. f. The clinical course of treatment followed. g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may have and the factors of employment listed in item no. 1.	

FROM EMPLOYING AGENCY	✓
6. Review and comment on employee's statement provided in response to questions 1-5. Give periods, degree and nature of exposure. Explain safety precautions. Give full details of any tests which were made to determine the concentration of irritants. Have other employees been similarly affected?	
7. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
8. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination and any other pertinent medical records. d. Most recent SF-50, Notification of Personnel Action.	

Form CA-35F
Rev. Aug '1988

OWCP Form CA-35F (continued)

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' compensation Act. You must provide facts and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 ("Federal Employees' Notice of Occupational Disease and Claim for Compensation"), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed to let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your Agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a postcard advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to improve the timeliness and adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the completed package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklist describes the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-35G

Evidence Required in Support of a Claim for Work-Related Psychiatric Illness

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

IF YOU ARE FILING A CLAIM FOR A PSYCHIATRIC CONDITION, THIS CHECKLIST DESCRIBES THE INFORMATION NEEDED FROM YOU AND YOUR EMPLOYING AGENCY. All the following information should be submitted with Form CA-2. Please return the checklist with your [illegible]. Check all appropriate boxes and provide the information or explanation requested should be legible and specific.

FROM EMPLOYEE	✓
1. Give a detailed chronological description of the particular employment factors which you believe caused your condition. Please identify dates, periods, events, people involved, etc.	
2. Describe the progress and development of the work-related condition from its beginning.	
3. Have you previously suffered from this or a similar condition? If so, give details of symptoms, disability and treatment records from all physicians and hospitals where you were treated.	
4. Give a brief description of your personal activities, hobbies, and any other employment.	
5. Describe changes or other sources of stress in your personal life occurring in the same time frame.	
6. Attach or forward a medical report as described on the reverse.	

FROM EMPLOYING AGENCY	✓
7. Review and comment on the employee's statements provided in response to questions 1–5. Submit statements from witnesses, if appropriate.	
8. Provide a detailed statement describing the duties of the employee and the manner in which the duties were performed. If the work was different or more stressful than that performed by other employees, this should be explained.	
9. Document any personnel actions described in the employee's statement, such as changes in assignment, grievances filed by the employee, and other adverse personnel actions.	
10. Give the number of hours worked per day, days per week and the extent of overtime duty worked.	
11. Provide a day-by-day listing of leave and leave without pay used due to this condition.	
12. Attach copies of the employee's: a. SF-171, Application for Employment. b. Position description with physical requirements. c. Preemployment medical examination. d. All other pertinent medical reports available. e. Most recent SF-50, Notification of Personnel Action.	

Form CA-35G
August 1995

OWCP Form CA-35G (continued)

MEDICAL REPORT FOR PSYCHIATRIC CLAIM

You should submit a medical report from your physician which includes:

a. History of brief clinical exam

b. Social and family history

c. Detailed description of your work situation and identification of the specific work factors contributing to your condition(s) or psychiatric condition.

d. Review of any non-industrial factors involved.

e. Mental status examination, with pertinent findings.

f. Results of psychological and personality testing.

g. Diagnosis according to DSM III.

h. Clinical course of treatment followed.

i. Prognosis with estimate of when you will be able to return to work.

j. Physician's opinion, with reasons for such opinion as to whether how and which factors of your employment caused, aggravated, precipitated, or accelerated your disability.

k. An assessment of your current condition, with specific details on how you can or cannot function in daily activities, including a discussion of any limitations you may have in your ability to give or take instruction, cooperate with others, work under deadlines, or any other pertinent factors which may affect your work capacity.

NOTICE TO EMPLOYEES FILING CLAIM FOR OCCUPATIONAL DISEASE

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees Compensation Act. You must provide factual and medical evidence to establish that a condition of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence may be a substantial burden. The attached checklist is designed to help you. Form CA-2 ("Federal Employee's Notice of Occupational Disease and Claim for Compensation") and your statements in support of the claim, and a report from your treating physician should be given to your agency Compensation Specialist at the same time. Please review the checklist and your statements. Check off each item as it is completed or as it is known when we can expect the information. Your supervisor and the Compensation Specialist will complete the applicable information requested and forward a complete and acceptable package to OWCP. If your agency has no Compensation Specialist or other person designated to forward information to OWCP, give this information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a postcard advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for early retirement benefits from the Office of Personnel Management (OPM) and receive compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your supervisor, doctor, lawyer or witness be able to understand what you said? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20 are rarely adequate in occupational disease cases.

NOTICE TO COMPENSATION SPECIALISTS AND SUPERVISORS

OWCP needs your help to minimize the conditions of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify employment factors and medical evidence needed to fully adjudicate the claim.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

1. Form CA-2, Federal Employees' Notice of Occupational Disease and Claim for Compensation; and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to work and return with the completed package. The second one should be for the employee's physician.

In addition to describing the evidence required from the employee, the checklist describes the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are received, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be given to the employee with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is still not available or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documentation are essential for the claims examiner to get a complete picture of the employment conditions.

We appreciate your cooperation in this effort.

[illegible]

OWCP Form CA-35H

Evidence Required in Support of A Claim for Work-Related Carpal Tunnel Syndrome

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

If you are claiming that your carpal tunnel or wrist problems are due to your job, use this checklist to identify the specific information needed from you and your employing agency to make a decision on the claim. All of the following information should be submitted with Form CA-2. Please return the checklist with documents attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE

1. Prepare a statement giving the following information:

   a. Provide an outline of your work history, including non-Federal employment and military service. For each job held, give your job title, agency/company name, and dates (per/dd) of employment.

   b. For each job title described, duties which required extension with or repeated movement of the wrist or hand. Describe nature and frequency of motions required and average number of hours a day/week you did such work.

   c. Describe hobbies, physical fitness or other activities outside of work which also involved extension or repeated movement of wrist/hand. State the nature of each such activity, years involved in each, and how many hours a week you engaged in such.

   d. If you have ever had an injury to the hand/arm/wrist or been diagnosed as having gout, arthritis, hypothyroidism, diabetes, a tumor, or deformity of the hand/wrist (formation), describe the injury or condition, and dates when injury occurred or condition was found.

   e. Give a brief chronological history of your hand/wrist problem. State which hand(s) are affected when you first experienced problems, nature of the problems and changes over time to present, and dates and nature of medical care obtained.

2. Ask all doctors who treated you to send you a copy of reports or notes describing the condition, testing and treatment given.

FROM EMPLOYING AGENCY

1. Review the employee's statement, giving the following information:

   a. Comment on the accuracy of the employee's statement describing Federal job duties involving use of hand/wrist.

   b. Provide a day-to-day listing of leave and leave without pay used by the employee due to carpal tunnel/wrist problems.

   c. Give date employee entered on duty in job requiring stated duties. Also give the attached dates and description(s) of any changes in work assignments due to employee's condition and date when duty changes resulted in changes in pay.

2. Send us copies of employee's:

   a. SF-171, Application for Employment.

   b. Position description with physical requirements for last job held.

   c. All available medical records, including record of pre-employment examination.

   d. SF-50s or equivalent documents for changes in assignment/pay due to condition.

3. Ask the doctor currently treating your condition to provide a complete current medical report to include the following specifics:

   a. Dates of examinations.

   b. Complete medical history of condition.

   c. Medical diagnosis of condition.

   d. Findings and test results, specifically including Results of Phalen's and Tinel's Sign tests, physical findings concerning sensation over palmar aspect of first three and one-half digits, and dorsal aspect of end joints of same digits, and any atrophy of the Thenar Eminence, returns of nerve conduction velocity, and electromyographic testing.

   e. Treatment to date and prognosis.

   f. Reasoned opinion explaining any medical relationship between the condition and your Federal job.

   It is MOST IMPORTANT that the doctor provide a detailed opinion as to the likely nature of the physical stresses attributable to specified duties of your Federal job and explain the medical reasoning which supports the opinions and conclusions.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Form CA-35H
October 1991

OWCP Form CA-35H (continued)

Notice to Employees Filing Claim for Occupational Disease

Diseases and illnesses which occur during or after Federal employment are not automatically covered by the Federal Employees' Compensation Act. You must provide factual and medical evidence to establish that conditions of employment caused or aggravated the disease or illness.

The Office of Workers' Compensation Programs (OWCP) understands that gathering the necessary evidence requires substantial effort. The attached checklist is designed to help you. Form CA-2 (Notice of Occupational Disease and Claim for Compensation), your statements in response to the checklist, and a report from your treating physician should all be given to your agency Compensation Specialist at the same time. Please return the checklist with your statements. Check off each item as it is completed or let us know when we can expect the information. Your supervisor and the Compensation Specialist will compile the additional information required and forward a complete and organized package to OWCP. If your agency has no Compensation Specialist or other person designated to forward information to OWCP, give the information directly to your supervisor.

Upon receipt of your claim, OWCP will create a case and assign it to a claims examiner for processing. You will receive a postcard advising you of the case number. Use this number on all future correspondence about your claim.

If you are eligible for Civil Service retirement, you may apply for both retirement benefits from the Office of Personnel Management (OPM) and workers' compensation benefits from OWCP. However, in most cases, you cannot receive both benefits for the same period of time.

HINTS: Are your statements legible? Would your statements make sense to someone who has never done your job? Do your statements answer the questions? Are your statements complete and accurate? A NARRATIVE REPORT FROM YOUR PHYSICIAN IS REQUIRED. Reports on medical forms, such as Form CA-20, are rarely adequate in occupational disease cases.

Notice to Compensation Specialists and Supervisors

OWCP needs your help to improve the timeliness of adjudication of occupational disease cases. We have developed checklists to help you and the employee submit a claim in an organized and complete manner. The checklists will help the claims examiner identify what information has been submitted and what is still outstanding.

Whenever an employee wants to file a claim for occupational disease or illness, please give him or her:

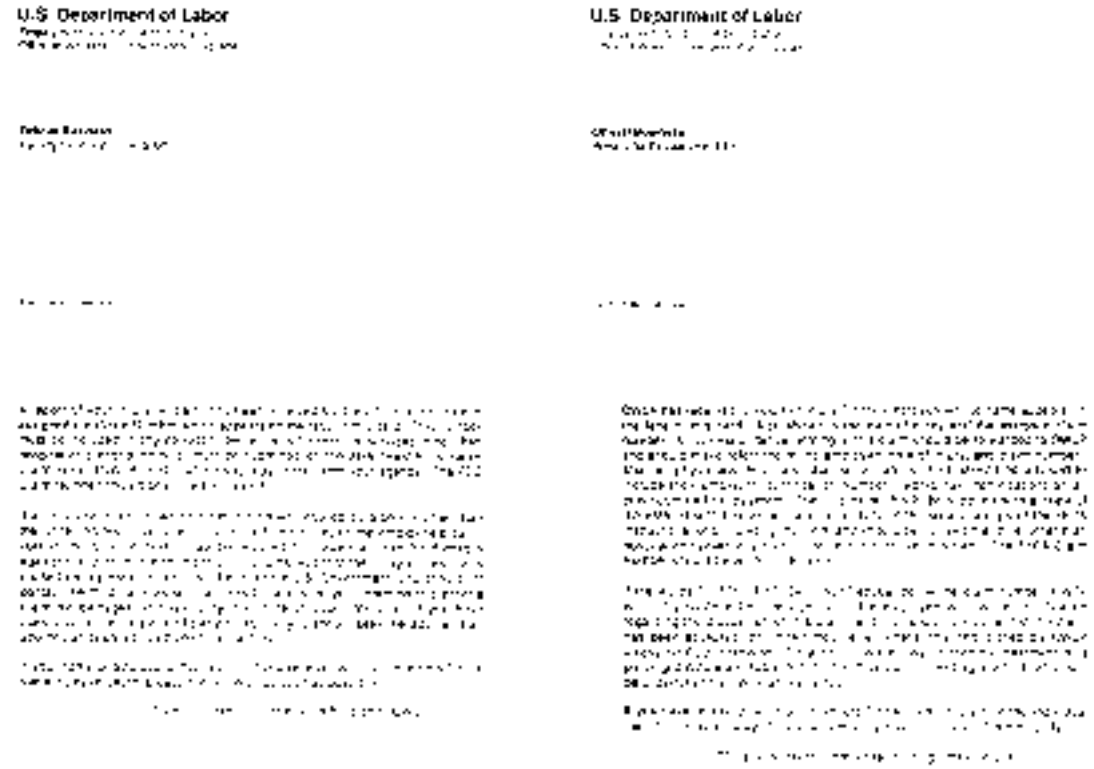
1. Form CA-2, Notice of Occupational Disease and Claim for Compensation, and

2. Two copies of the checklist describing evidence required in support of the claim. One checklist is for the employee to mark and return with the complete package. The second checklist is for the employee to take to the physician.

In addition to describing the evidence required from the employee, the checklists describe the information to be submitted by the employing agency. When Form CA-2 and the employee's statements are returned, you are required by instructions on the CA-2 to forward them to OWCP within ten working days. Statements and documents required from the agency should be submitted with the CA-2 whenever possible. Please use the checklist to note what information from the employing agency is enclosed, unavailable or pending. If pending, please give the anticipated mailing date. Agency comments, statements and documents are essential for the examiner to get a well rounded picture of the employment conditions.

We appreciate your cooperation in this effort.

OWCP Form CA-801


U.S. Department of Labor

U.S. Department of Labor

OWCP CA-1207

U.S. DEPARTMENT OF LABOR

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, DC 20210

File No.
Employee's SSN.
Date of Injury

This injury you sustained on the above date entitles you to compensation and medical benefits provided by the Federal Employees' Compensation Act. You may receive compensation if: (a) you enter a leave without-pay status or (b) you choose to "buy back" the leave you have already used or will be using as a result of the injury.

Based on information presently available to the Office of Workers' Compensation Programs (OWCP), you are eligible for compensation as follows:

1. Period	2. Gross Compensation
From To:	

If you wish to "buy back" leave you previously used, you must: (1) Refund to your employing agency the amount of pay they state you received for leave during the above noted period. This amount will be indicated in item 6 on the reverse of this form and (2) Have your leave record changed from "leave with pay" to "leave without pay" for the period in question.

If you are unable to refund the entire amount of leave pay received, you may arrange with your employing agency to pay the difference between the leave pay and the gross compensation due.

To receive compensation for all or part of the leave period shown in item 1 above, you should complete items 1 through 4 on the reverse of this letter. An accountable officer of your employing agency (Postal Data Center in Postal Service) should then complete items 5 through 9 and return the form to the OWCP. If you wish the OWCP to pay your compensation direct to your agency, please check box (b) in item 4.

If you have not returned to work and you lose pay or suffer a leave without pay status in the future, you should file claim for compensation on Form CA-8 which can be obtained from your employing agency or from the OWCP.

Sincerely,

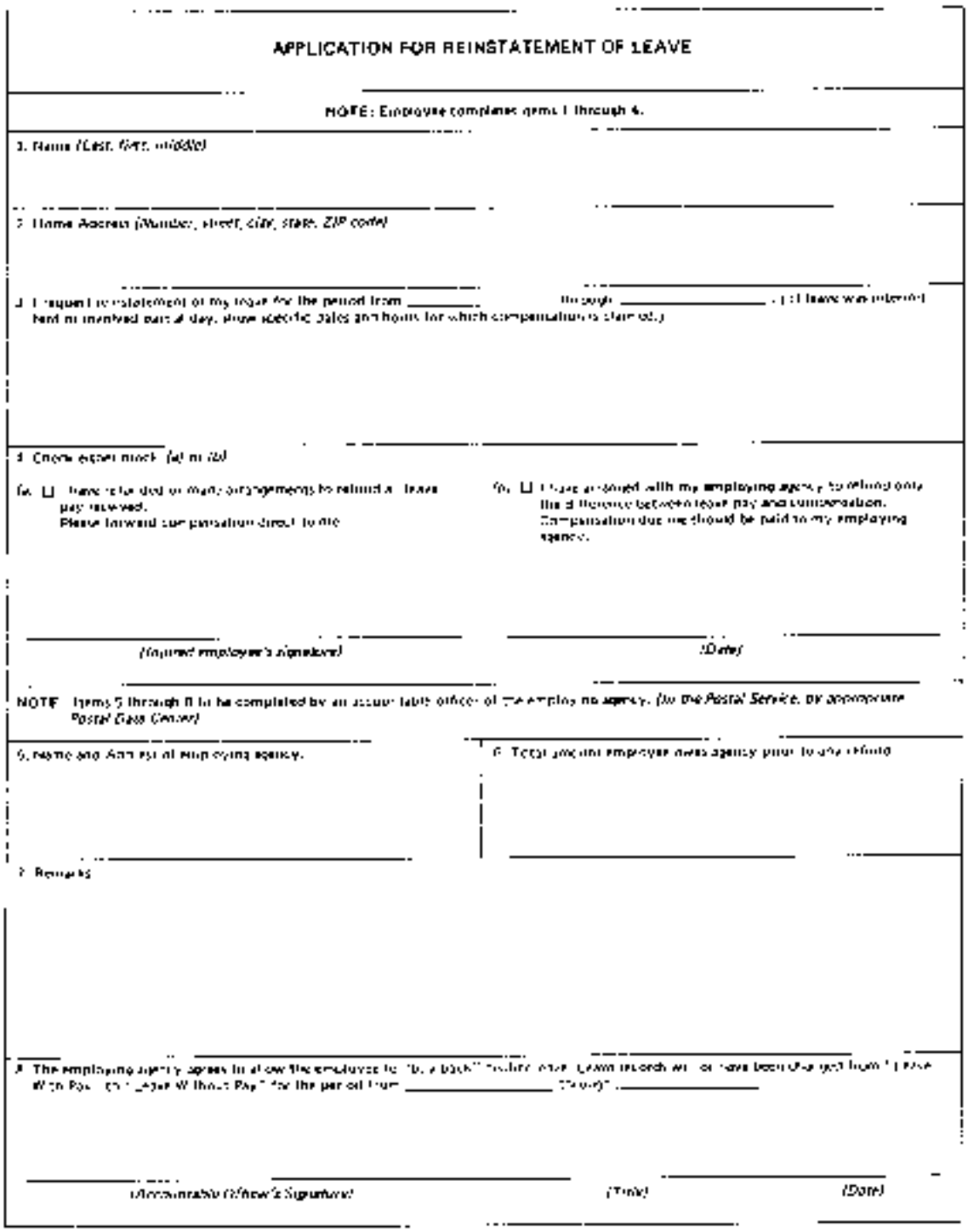
Supervisory Claims Examiner

NOTICE: If a claimant repurchases sick or annual leave during the same tax year in which the leave was used, the amount repaid is excluded from the claimant's taxable income for the year. This procedure would require the employing agency to amend the claimant's Form W-2 for that year. If repurchase is made for leave used in a prior tax year, the claimant may not retroactively adjust the tax return for the year during which the leave in question was used. However, the claimant may deduct as a loss for the current tax year the amount repaid, provided deductions are itemized. In such instances, it is not necessary to reflect the repurchase through the payroll system, nor is it necessary to amend the Form W-2 for the year the leave was used. Further questions regarding this should be addressed to the Internal Revenue Service.

Include your address, ZIP code, and file number on all correspondence

Enc. CA-1207
Rev. May 1980

OWCP CA-1207 (continued)



APPLICATION FOR REINSTATEMENT OF LEAVE

NOTE: Employee completes items 1 through 4.

1. Name (Last, first, middle)

2. Home Address (Number, street, city, state, ZIP code)

3. I request reinstatement of my leave for the period from _____ through _____. (If leave was interrupted and an overlap exists, show specific dates and hours for which compensation is claimed.)

4. Check appropriate block (a) or (b)

(a) ☐ I have not made any arrangements to refund the leave pay received.
Please forward the compensation check to me.

(b) ☐ I have arranged with my employing agency to refund only the difference between leave pay and compensation.
Compensation due me should be paid to my employing agency.

_____ _____
(Injured employee's signature) (Date)

NOTE: Items 5 through 8 to be completed by an accountable officer of the employing agency. (In the Postal Service, the appropriate Postal Data Center)

5. Name and Address of employing agency.

6. Total amount employee owes agency prior to any refund

7. Remarks

8. The employing agency agrees to allow the employee to "buy back" his/her sick leave or annual leave which was used or will be used to cover the period of "Leave Without Pay" for the period from _____ through _____.

_____ _____ _____ _____
(Accountable Officer's Signature) (Title) (Date)

Form 35

PAYROLL SUMMARY AND CERTIFICATION

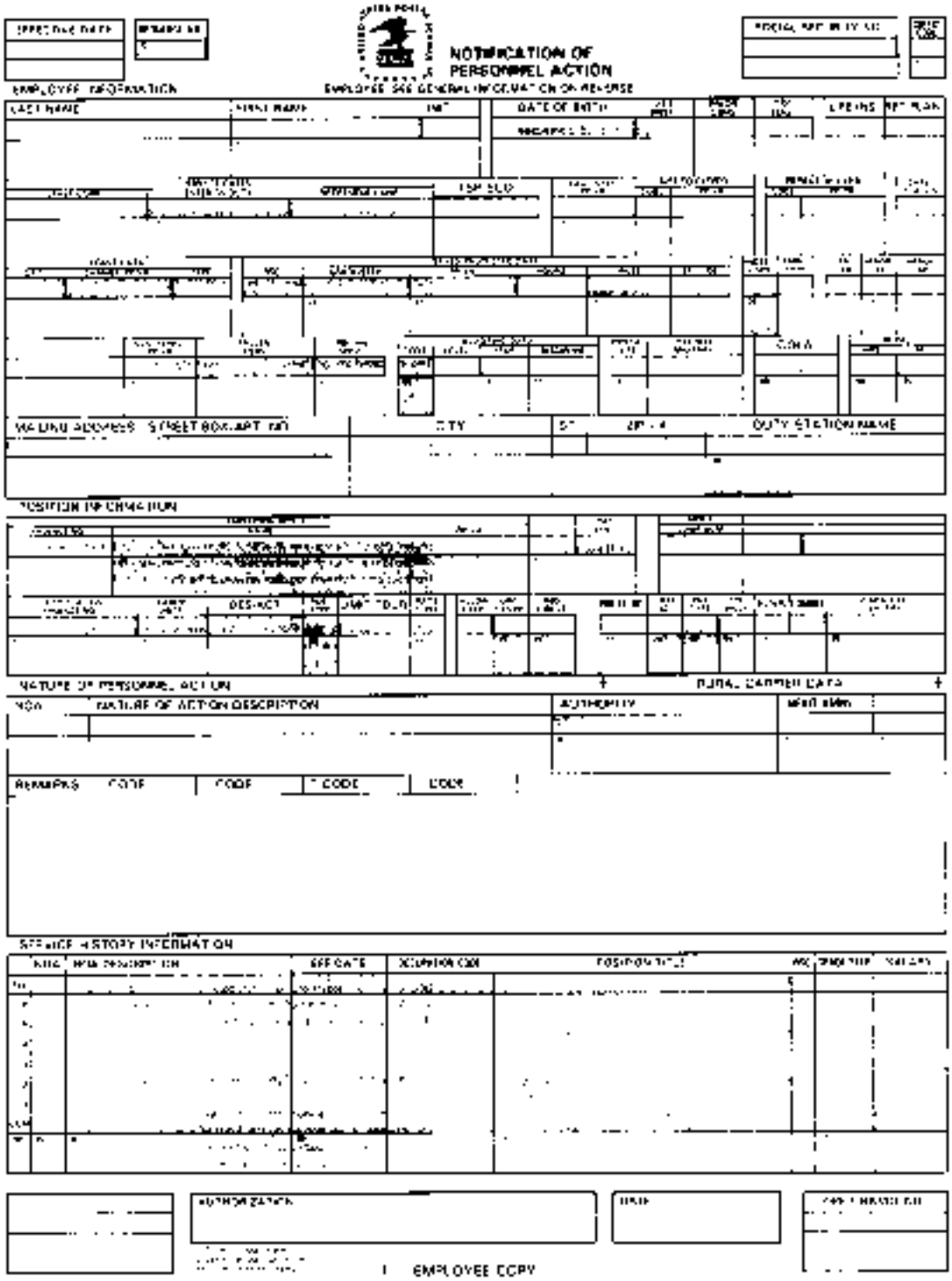
	PAYROLL PERIOD	VOUCHER NUMBER
MINNEAPOLIS ISSUE ASC PC U S POSTAL SERVICE [illegible] FORT SNELLING MN 55111-9650	PAY PERIOD 20 YEAR 1995 FROM 09/09/95 TO 09/22/95	CHECK SYMBOL 8110

NET PAYMENT TO EMPLOYEE	0.00	PAYMENT DESCRIPTION
SOCIAL SECURITY	0.00	PAYROLL
CIVIL SERVICE RETIREMENT	0.00	
MEDICARE WITHHOLDING TAX	0.00	
FEDERAL WITHHOLDING TAX	0.00	
HEALTH BENEFIT	0.00	
STATE WITHHOLDING TAX	0.00	
LOCAL WITHHOLDING TAX	0.00	
UNION DUES	0.00	
POST OFFICE INVEST	0.00	
POST OFFICE INVEST TERM. LEAVE	0.00	
OTHER AGENCY INVEST	0.00	
CHILD SUPPORT		
DIRECT PAYMENT	0.00	
PAY COMMITMENT	0.00	
TAX LEVY	0.00	
GARNISHMENT		
DIRECT PAYMENT	0.00	
ESCROW	0.00	
PEP ADVANCE	0.00	
OPTIONAL GROUP LIFE INSURANCE	0.00	
U S SAVINGS BONDS	0.00	DATE OF CHECK
CHARITY	0.00	
MISC INSURANCE		09/29/95
APWU - VEBA INS EFT	0.00	
NALC - HBA INS EFT	0.00	NUMBER OF VALID CHECKS
NALC - VEBA INS EFT	0.00	0
TSP LOAN	0.00	
FSA HEALTHCARE	0.00	NUMBER OF VOIDED CHECKS
FSA DEPENDENT CARE	0.00	0
THRIFT SAVINGS PLAN LOAN (EFT)	0.00	
THRIFT SAVINGS PLAN	0.00	
ALLOTMENTS (EFT)	0.00	
MILITARY DUP DEDS	0.00	ATTACHED IS THE LIST
NET TO BANK (EFT)	0.00	OF CHECK NUMBERS
GROSS PAYMENT	0.00	
ALTERNATE TRANSPORTATION P	0.00	
EARNED ACCUM CREDIT	0.00	
LAW ENFORCEMENT PREMIUM INSPECTIONS	0.00	
NDAT	0.00	
SPECIAL PAY ADJUSTMENT INSPECTORS	0.00	
TERRITORY COST OF LIVING ALLOWANCE	0.00	
CARRIER DRIVE OUT ALLOWANCE	0.00	
EQUIPMENT MAINTENANCE ALLOWANCE	0.00	
EMPLOYEE VEHICLE USE	0.00	
SPECIAL DELIVERY	0.00	
SUPERVISOR VEHICLE USE	0.00	
GROSS EARNINGS	0.00	

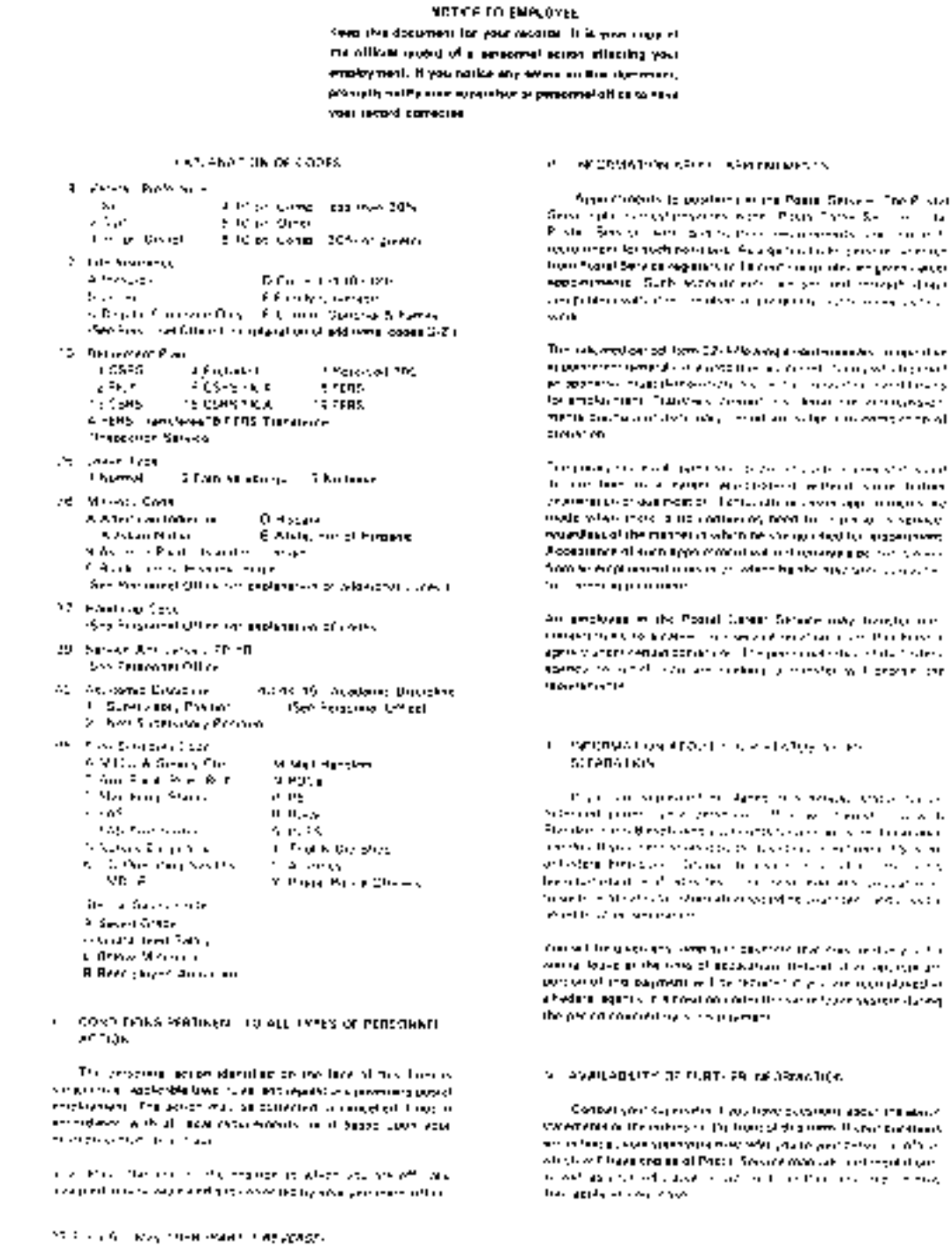
OFFICIAL TITLE Manager Scott Davis

SIGNATURE DATE 9/29/95

Form 50


NOTIFICATION OF
PERSONNEL ACTION
EMPLOYEE INFORMATION
LAST NAME
FIRST NAME
DATE OF BIRTH
POSITION INFORMATION
NATURE OF PERSONNEL ACTION
FEDERAL EMPLOYMENT DATA
NATURE OF ACTION DESCRIPTION
AUTHORITY
REMARKS
SERVICE HISTORY INFORMATION
EFF DATE
EMPLOYEE COPY

Form 50 (continued)



NOTICE TO EMPLOYEE

Keep this document for your records. It is your copy of the official record of a personnel action affecting your employment. If you notice any errors on this document, promptly notify your supervisor or personnel office so we can make your record correct.

EXPLANATION OF CODES

8 Nature Pay Basis
Hr 4 Hr or Comp less than 20%
Day 5 Hr or Comp
Unit or Other 6 Hr or Comp 20% or greater

9 Life Insurance
A Regular B Optional (10 times annual rate)
C Regular + Optional D Optional (Standard + Extra)
E Regular + Optional (Standard + Extra) F Optional (Standard + Family)
See Personnel Office for explanation of additional codes (C-F)

10 Retirement Plan
1 CSRS 2 Regular FICA 3 Special FICA
4 FERS 5 CSRS Offset 6 CSRS
7 FERS 8 FERS Transferee 9 FERS
A FERS Transferee B FERS Transferee
Transferee Service

11 Work Schedule
F Full-time P Part-time I Intermittent

20 Veterans Code
A Attributable to Service D Disability
C Compensable E Compensable
V Veteran Preference Only Z Not a Veteran
See Personnel Office for explanation of additional codes

22 Handicap Code
See Personnel Office for explanation of codes

29 Service Computation Date - SCD
See Personnel Office

32 Appointment Limitation Code: NTE YR MO Duration
1 Temporary, Limited Not to exceed 1 year
2 Term Limited Not to exceed 4 years

38 Position Occupied
A WG/WL/WS Grade 01 M Merit Promotion
B Non-Merit Promotion N PCS
C Reinstatement P PD
D Transfer Q QI
E Reassignment R Reduction
F Demotion S Separation
G Time-in-Grade T Transfer
H Change to Lower Grade U Other
W Wage Board
Z Reemployment

40 LOCALITY PAY AREA
Locality Pay Area

41 SUPERVISORY STATUS
Supervisory Status

42 WORK SCHEDULE
Work Schedule

43 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

44 POSITION OCCUPIED
Position Occupied

45 APPROPRIATION CODE
Appropriation Code

46 BARGAINING UNIT STATUS
Bargaining Unit Status

47 DUTY STATION CODE
Duty Station Code

48 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

49 PAY RATE DETERMINANT
Pay Rate Determinant

50 PAY PLAN
Pay Plan

51 ADJUSTED BASIC PAY
Adjusted Basic Pay

52 RETIREMENT PLAN
Retirement Plan

53 SUPERVISORY DIFFERENTIAL
Supervisory Differential

54 HOURS
Hours

55 PAY BASIS
Pay Basis

56 TOTAL SALARY
Total Salary

57 AWARD AMOUNT
Award Amount

58 FEGLI
FEGLI

59 ANNUITY PLAN
Annuity Plan

60 LABOR ORGANIZATION CODE
Labor Organization Code

61 WORK SCHEDULE
Work Schedule

62 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

63 POSITION OCCUPIED
Position Occupied

64 APPROPRIATION CODE
Appropriation Code

65 BARGAINING UNIT STATUS
Bargaining Unit Status

66 DUTY STATION CODE
Duty Station Code

67 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

68 PAY RATE DETERMINANT
Pay Rate Determinant

69 PAY PLAN
Pay Plan

70 ADJUSTED BASIC PAY
Adjusted Basic Pay

71 RETIREMENT PLAN
Retirement Plan

72 SUPERVISORY DIFFERENTIAL
Supervisory Differential

73 HOURS
Hours

74 PAY BASIS
Pay Basis

75 TOTAL SALARY
Total Salary

76 AWARD AMOUNT
Award Amount

77 FEGLI
FEGLI

78 ANNUITY PLAN
Annuity Plan

79 LABOR ORGANIZATION CODE
Labor Organization Code

80 WORK SCHEDULE
Work Schedule

81 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

82 POSITION OCCUPIED
Position Occupied

83 APPROPRIATION CODE
Appropriation Code

84 BARGAINING UNIT STATUS
Bargaining Unit Status

85 DUTY STATION CODE
Duty Station Code

86 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

87 PAY RATE DETERMINANT
Pay Rate Determinant

88 PAY PLAN
Pay Plan

89 ADJUSTED BASIC PAY
Adjusted Basic Pay

90 RETIREMENT PLAN
Retirement Plan

91 SUPERVISORY DIFFERENTIAL
Supervisory Differential

92 HOURS
Hours

93 PAY BASIS
Pay Basis

94 TOTAL SALARY
Total Salary

95 AWARD AMOUNT
Award Amount

96 FEGLI
FEGLI

97 ANNUITY PLAN
Annuity Plan

98 LABOR ORGANIZATION CODE
Labor Organization Code

99 WORK SCHEDULE
Work Schedule

100 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

101 POSITION OCCUPIED
Position Occupied

102 APPROPRIATION CODE
Appropriation Code

103 BARGAINING UNIT STATUS
Bargaining Unit Status

104 DUTY STATION CODE
Duty Station Code

105 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

106 PAY RATE DETERMINANT
Pay Rate Determinant

107 PAY PLAN
Pay Plan

108 ADJUSTED BASIC PAY
Adjusted Basic Pay

109 RETIREMENT PLAN
Retirement Plan

110 SUPERVISORY DIFFERENTIAL
Supervisory Differential

111 HOURS
Hours

112 PAY BASIS
Pay Basis

113 TOTAL SALARY
Total Salary

114 AWARD AMOUNT
Award Amount

115 FEGLI
FEGLI

116 ANNUITY PLAN
Annuity Plan

117 LABOR ORGANIZATION CODE
Labor Organization Code

118 WORK SCHEDULE
Work Schedule

119 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

120 POSITION OCCUPIED
Position Occupied

121 APPROPRIATION CODE
Appropriation Code

122 BARGAINING UNIT STATUS
Bargaining Unit Status

123 DUTY STATION CODE
Duty Station Code

124 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

125 PAY RATE DETERMINANT
Pay Rate Determinant

126 PAY PLAN
Pay Plan

127 ADJUSTED BASIC PAY
Adjusted Basic Pay

128 RETIREMENT PLAN
Retirement Plan

129 SUPERVISORY DIFFERENTIAL
Supervisory Differential

130 HOURS
Hours

131 PAY BASIS
Pay Basis

132 TOTAL SALARY
Total Salary

133 AWARD AMOUNT
Award Amount

134 FEGLI
FEGLI

135 ANNUITY PLAN
Annuity Plan

136 LABOR ORGANIZATION CODE
Labor Organization Code

137 WORK SCHEDULE
Work Schedule

138 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

139 POSITION OCCUPIED
Position Occupied

140 APPROPRIATION CODE
Appropriation Code

141 BARGAINING UNIT STATUS
Bargaining Unit Status

142 DUTY STATION CODE
Duty Station Code

143 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

144 PAY RATE DETERMINANT
Pay Rate Determinant

145 PAY PLAN
Pay Plan

146 ADJUSTED BASIC PAY
Adjusted Basic Pay

147 RETIREMENT PLAN
Retirement Plan

148 SUPERVISORY DIFFERENTIAL
Supervisory Differential

149 HOURS
Hours

150 PAY BASIS
Pay Basis

151 TOTAL SALARY
Total Salary

152 AWARD AMOUNT
Award Amount

153 FEGLI
FEGLI

154 ANNUITY PLAN
Annuity Plan

155 LABOR ORGANIZATION CODE
Labor Organization Code

156 WORK SCHEDULE
Work Schedule

157 PART-TIME HOURS PER PAY PERIOD
Part-time Hours

158 POSITION OCCUPIED
Position Occupied

159 APPROPRIATION CODE
Appropriation Code

160 BARGAINING UNIT STATUS
Bargaining Unit Status

161 DUTY STATION CODE
Duty Station Code

162 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

163 PAY RATE DETERMINANT
Pay Rate Determinant

164 PAY PLAN
Pay Plan

165 ADJUSTED BASIC PAY
Adjusted Basic Pay

166 RETIREMENT PLAN
Retirement Plan

167 SUPERVISORY DIFFERENTIAL
Supervisory Differential

168 HOURS
Hours

169 PAY BASIS
Pay Basis

170 TOTAL SALARY
Total Salary

171 AWARD AMOUNT
Award Amount

172 FEGLI
FEGLI

173 ANNUITY PLAN
Annuity Plan

174 LABOR ORGANIZATION CODE
Labor Organization Code

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187 HOURS
Hours

188 PAY BASIS
Pay Basis

189 TOTAL SALARY
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190 AWARD AMOUNT
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191 FEGLI
FEGLI

192 ANNUITY PLAN
Annuity Plan

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Labor Organization Code

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Position Occupied

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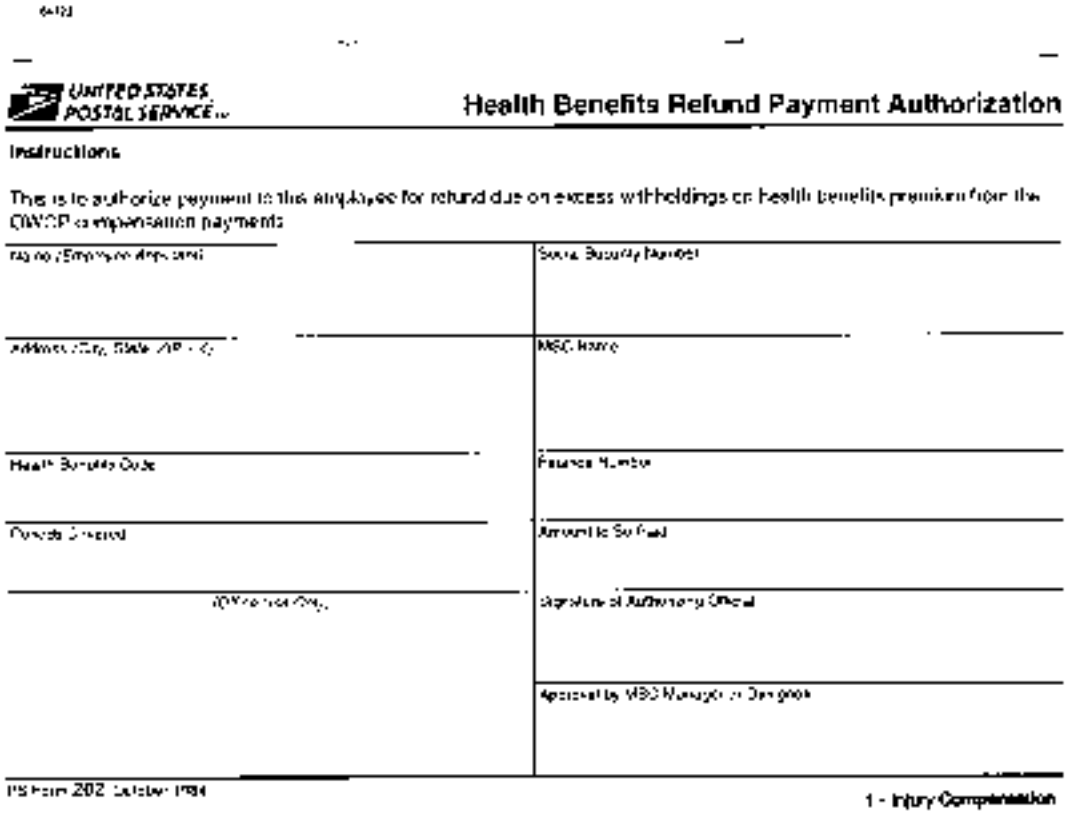
Appropriation Code

198 BARGAINING UNIT STATUS
Bargaining Unit Status

199 DUTY STATION CODE
Duty Station Code

200 MARITAL STATUS/NUMBER OF EXEMPTIONS
Marital Status/Number of Exemptions

Form 202



UNITED STATES POSTAL SERVICE

Health Benefits Refund Payment Authorization

Instructions

This is to authorize payment to the employee for refund due on excess withholdings on health benefits premium from the OWCP compensation payments.

Reg no / Employee Applicant

Social Security Number

Address (City, State, ZIP + 4)

MSC Name

Health Benefits Code

Finance Number

Periods Covered

Amount to be Paid

(Dollars and Cents)

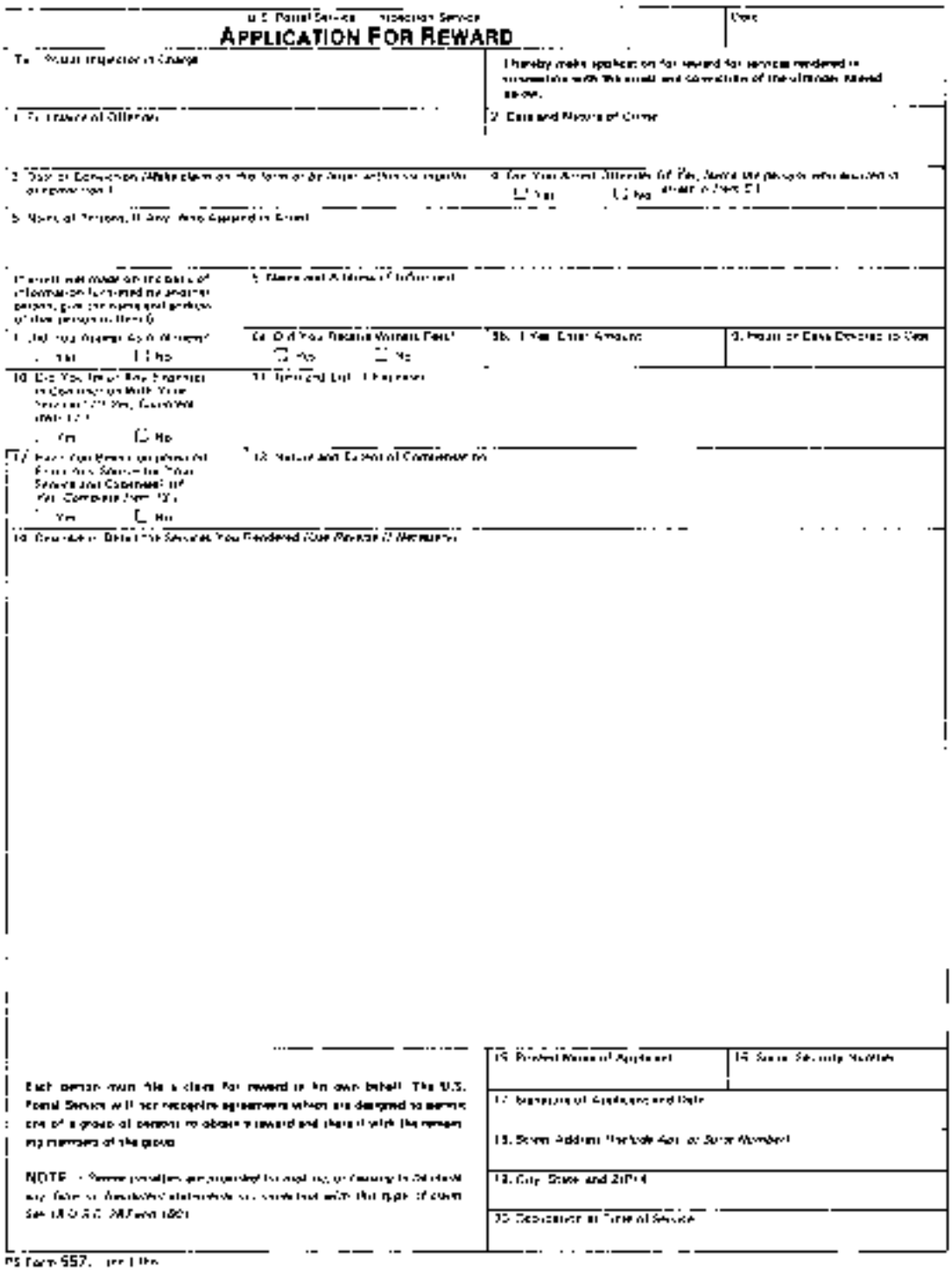
Signature of Authorizing Official

Approved by MSC Manager or Designee

PS Form 202 October 1984

1 - Injury Compensation

Form 557



U.S. Postal Service — Inspection Service

APPLICATION FOR REWARD

Case

To: (Postal Inspector in Charge)

I hereby make application for reward for services rendered in connection with the arrest and conviction of the individuals named above.

1. Fr: (Name of Officer)

2. Date and Nature of Crime

3. Date of Conviction (Attach copies of the form of the Judgment and Commitment Order)

4. Did You Arrest Offender(s)? If No, Name the Person who Assisted or Furnished Information Leading to Arrest (See Item 5)

☐ Yes ☐ No

5. Name of Person, If Any, Who Assisted in Arrest

If you will not make all of the facts of information furnished by another person, give the name and address of that person. (Item 6)

6. Name and Address of Informant

7. Did You Appear As A Witness?

☐ Yes ☐ No

8a. Did You Receive Witness Fee?

☐ Yes ☐ No

8b. If Yes, Enter Amount

9. Hours of Case Devoted to Work

10. Did You Have Any Expenses in Connection With Your Services? (If Yes, Complete Item 11)

☐ Yes ☐ No

11. Itemized List of Expenses

12. Nature and Extent of Contribution

13. Date(s) and Place(s) of Arrest(s) Shown in Your Services and Contribution (If Any) Complete Item 12)

☐ Yes ☐ No

14. Circumstances Under Which Services You Rendered (Use Reverse If Necessary)

Each person must file a claim for reward in his own behalf. The U.S. Postal Service will not recognize agreements which are designed to permit one of a group of persons to obtain a reward and share it with the remaining members of the group.

NOTE: Persons who are convicted for making or causing to be made any false or fraudulent statements are subject to fine and imprisonment. See 18 U.S.C. 287 and 1001.

15. Printed Name of Applicant

16. Social Security Number

17. Signature of Applicant and Date

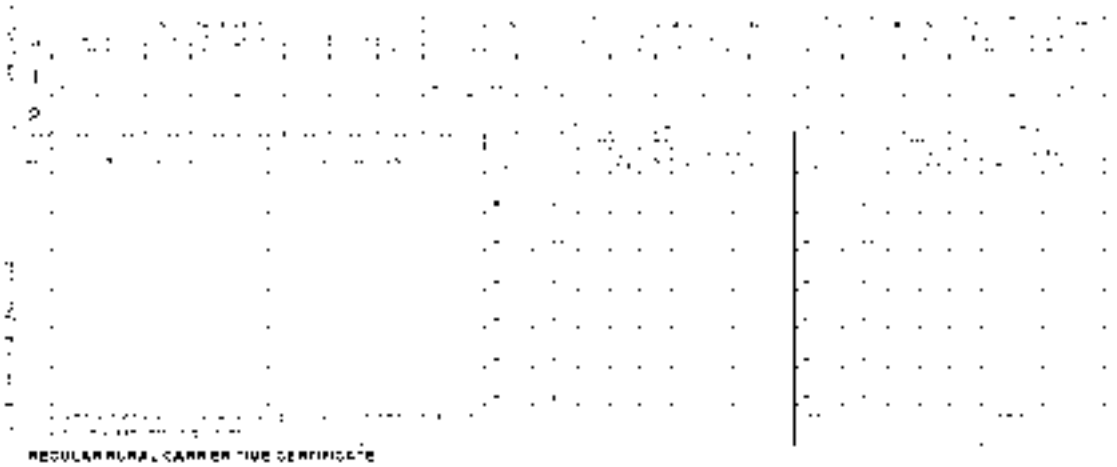
18. Street Address (Include Apt. or Suite Number)

19. City, State, and ZIP+4

20. Occupation at Time of Service

PS Form 557, [illegible]

Form 1314 (front and reverse)



Identify all Absences with the following codes

A - Annual Leave
C - Court or Jury
D - Donated Leave
O - Absence Other Than Above
H - Holiday Leave
V - Holiday Work
W - OIC (WOP)
L - Leave W/O Pay
L - Limited Duty
M - Military Leave
O - Other Leave *
F - OWCP
X - Scheduled Day Taken (Previous Pay Period)
N - Scheduled Day Worked (No Sub)
S - Sick Leave
T - Standard Duty
T - Training
K - 10 Day Route
L - 11 Day Route

* When Other Leave is recorded, reason must be given. Explanation

** Unpaid day taken to avoid going into a 11 day. Does not apply to casuals, non-career utility PSEs or rural carrier associates (See F8, 9, newly appointed regular rural carriers with LSA code of A)

Form 1769

Accident Report

Instructions

General Information

The supervisor of the employee or operation involved must complete this form for all accidents regardless of extent of injury or amount of damage. Review all instructions and codes before completing the form. The Safety and Health office is available for assistance.

Information forwarded to the Office of Workers' Compensation Programs (OWCP) must be different from information on this form.

Multiple Person Accidents

When more than one person is injured as a result of the accident, complete a separate form for each injured and cite the same accident number on each form. Complete all items for the first person listed on the accident. For additional persons involved, complete only items 1-3, 17-55 below. If more than one postal employee is involved in the accident, follow the instructions listed above, regardless of whether there was injury or not.

Submission Procedures

1. The supervisor must complete this form within 24 hours of the date of the accident or the date of illness, or the date they were notified of the situation. The next level supervisor must verify all information on the form.
2. The Manager, Safety and Health Services at the Division has the responsibility for reviewing the accuracy of the coding submitted on each PS Form 1769, *Accident Report*, or electronically entered into the Human Resources Information System (HRIS) Safety and Health Subsystem and accident log. If the codes on PS Form 1769 do not match with the narrative submitted by the supervisor of the employee or operation involved, the Manager, Safety and Health Services, is responsible for resolving the inconsistency.
3. The installation head forwards the original accident report to the safety office within 3 calendar days of the accident.
4. The local office must retain a copy of all reports (operation or investigation) that will be for 5 years (except accidently lost or improperly coded OSHA may be returned to originating office by the safety office. They must be corrected and resubmitted within 3 calendar days of receipt.
5. The safety office must:
   - review the completed form to ensure accuracy of codes
   - coordinate any changes with the reporting office.
   - complete necessary items
   - accept number and enter the accident information into the HRIS Safety and Health Subsystem within 1 calendar day of receipt, and
   - return the original copy for a period of 5 years.

Determining Reportable Accidents

The safety office assigns a number to all forms (item 3), using HRIS guidelines, for both reportable and nonreportable incidents, including unreported or occupational illness cases when it covers any of the following kinds of injuries, illnesses or damages:

1. All occupational traumatic injuries to postal employees regardless of whether the employee elects to file a claim (CA-1 *Federal Employee Notice of Traumatic Injury & Claim for Continuation of Pay/Compensation* or Form CA-5 or *U.S. Dept. of Labor — Office Supervisors Report of Employee's Death*) is submitted to OWCP, and regardless of whether or not the OWCP claim is controverted.

   EXCEPTION: A first aid case must be logged and coded (5 or more days) on this form. The report must be filed as a nonreportable case at the safety office when first aid case (NOT exceeding 2 visits as provided by postal medical personnel or contract facility facilities) is one the accident involves property damage such as may occur with a motor vehicle accident.

   NOTE: Cases with medical visits (for examination) are not to be coded as first aid cases.

2. All occupational illnesses, including fatal or critical CA-2 *Federal Employee's Notice of Occupational Disease and Claim for Compensation* or CA-8 in addition to OWCP.

   EXCEPTION: If an occupational illness, the form must be forwarded to the safety office for recording in the HRIS. These cases will be logged, assigned a reporting code and number, pending determination by the OWCP. Safety offices will maintain OWCP case files and update the status of the case in the HRIS. Instructions for amendments or changes are provided in HRIS Safety and Health Subsystem.
3. Injuries or fatalities to non-postal persons on postal premises.
4. All motor vehicle accidents.
5. Property damage of $500 or more, regardless of ownership.
6. Fire damage of $100 or more, regardless of ownership.

Adjustments and Deletions

Whenever there is a change in status or if you discover an error in a previously filed 1769, within 3 calendar days send a copy of the Form 1769 and written particulars and documents supporting the amendment/deletion to the servicing safety office for action.

PS Form 1769, September 1991 (S 1 of 3) (Instructions)

Form 1769 (continued)

Instructions for Items 1-61

Item 1 — **Post Office, Station, Branch, Unit** (City, State & ZIP Code) – Self-explanatory

Item 2 — **Finance Number** – Self-explanatory

Item 3 — **Installation ID** – The Installation ID is a 4-digit code

Item 4 — **Accident Number** – The safety office assigns consecutive accident numbers starting with 0001, then 0002, etc. Keep a record of used numbers to duplicate or missing numbers will create unnecessary correspondence. Start with 0001 the following FY

Item 5 — **Kind of Accident** – Check the appropriate box

Motor Vehicle – Any mechanically or electrically powered device designed for movement, not operated on rails, upon which or by which any person or property can be transported or drawn upon a land highway. The load on a motor vehicle is considered part of the vehicle.

Do not consider equipment such as vehicles operated entirely on rails, bicycles, or animal-powered or motor vehicles.

A motor vehicle accident is any accident involving a motor vehicle which occurs on official postal business, regardless of the ownership of the vehicle and which results in death, injury or property damage of one dollar or more, unless the vehicle is legally parked (see note below) and no property was damaged or in what action, where the accident occurred, or who was responsible is not a factor.

NOTE: A legally parked vehicle is one which the engine is turned off, the driver is not operating the controls, and the vehicle is parked where it is legal to do so. Temporarily "stopping" a vehicle without turning off the ignition to load/unload mail, properly, or service it, or a vehicle stopped at a stop sign, police signal or stalled in traffic does not constitute a legally parked vehicle. If special written permission has been granted by appropriate local authorities to park in designated "No Parking" areas, and the postal vehicle is otherwise properly parked, the event may be classified as a parked vehicle accident.

Natural Event – A nature event accident is the occurrence limited solely to property damage caused by such natural events as hurricane, flood, lightning, earthquake, windstorm, hail, etc.

Other – This code is used to classify accidents involving vandalism or where only a non-employee was in an accident on postal premises. It shall not be used for accidents involving "on-duty" postal employees. Example: A customer falls on a postal walk.

Item 6. — **Fire Involved** – Check appropriate box on the form. If box 2 or 3 is checked, Item 23 must be a fire code (F100 - F91).

1 – None

2 – Building and Contents (Fire in any type of structure as well as all equipment, vehicles, mines, supplies or materials on, under, or within the structure)

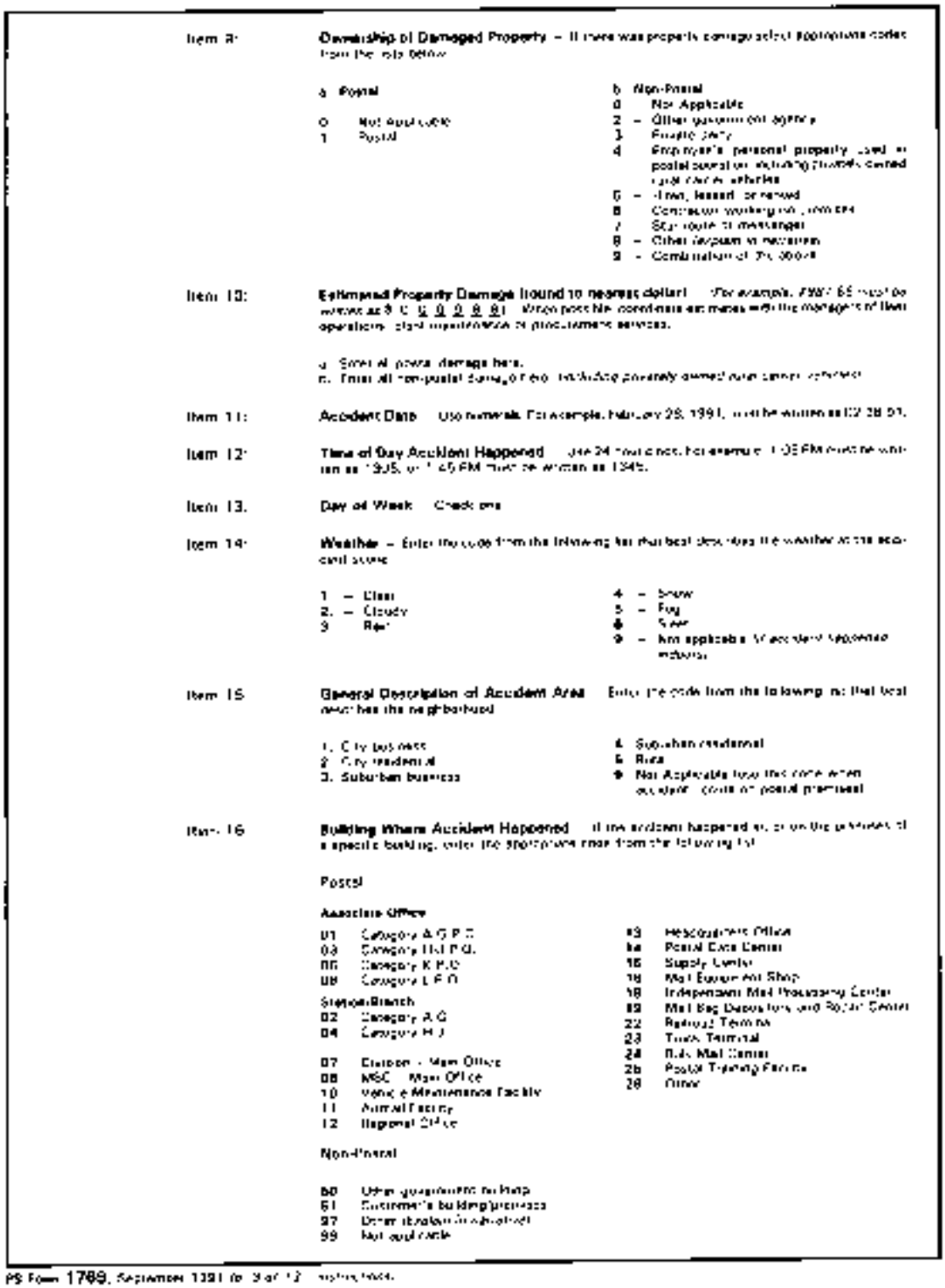
3 – Other (Includes open fire(s), fires in a vehicle or ship boxes, vehicles or any other fires not in a building).

Item 7. — **Accident Recalculation** – Check applicable box. If box 2 or 3 is checked also complete Items 9 & 10. If box 2 is checked, include a non-chargeable case. There is no requirement to file a report. That is, no injury or property damage occurred as a result of accident.

Item 8: — **Was On-Site Investigation Conducted By Immediate Supervisor?** – Check one

PS Form 1769, September 1991 (p. 2 of 12 - continued)

Form 1769 (continued)



Item 9: **Ownership of Damaged Property** – If more than one property damaged, select appropriate codes from the lists below.

a. Postal

0 Not applicable
1 Postal

b. Non-Postal

0 Not Applicable
2 – Other government agency
3 Private party
4 Employee's personal property used in postal operations (including those owned and used by others)
5 – Town, leased or rented
6 Contractor working on premises
7 Sub-route or messenger
8 – Other (explain in narrative)
9 – Combination of the above

Item 10: **Estimated Property Damage** (round to nearest dollar) For example, $987.65 would be written as $ 0 0 0 9 8 8 Write "0000" if no damage. Write possible conditions or names of the managers of their operations that might assist in claims settlement.

a. Enter all postal damage here.
b. Enter all non-postal damage here. Include privately owned automobiles.

Item 11: **Accident Date** Use numerals. For example, February 28, 1991, would be written as 02 28 91.

Item 12: **Time of Day Accident Happened** Use 24 hour clock. For example, 1:05 PM would be written as 1305, or 1:45 PM would be written as 1345.

Item 13: **Day of Week** Check one.

Item 14: **Weather** – Enter the code from the following list that best describes the weather at the accident scene.

1 – Clear
2 – Cloudy
3 Rain
4 – Snow
5 – Fog
6 Sleet
9 – Not applicable (if accident happened indoors)

Item 15: **General Description of Accident Area** Enter the code from the following list that best describes the neighborhood.

1. City business
2. City residential
3. Suburban business
4. Suburban residential
5. Rural
9 Not Applicable (use this code when accident occurs on postal premises)

Item 16: **Building Where Accident Happened** If the accident happened in or on the premises of a specific building, enter the appropriate code from the following list.

Postal

Associate Office

01 Category A, C, P, T
03 Category D, I, P, Q
05 Category K, P, O
08 Category L, P, O

Station/Branch

02 Category A, C
04 Category H, J

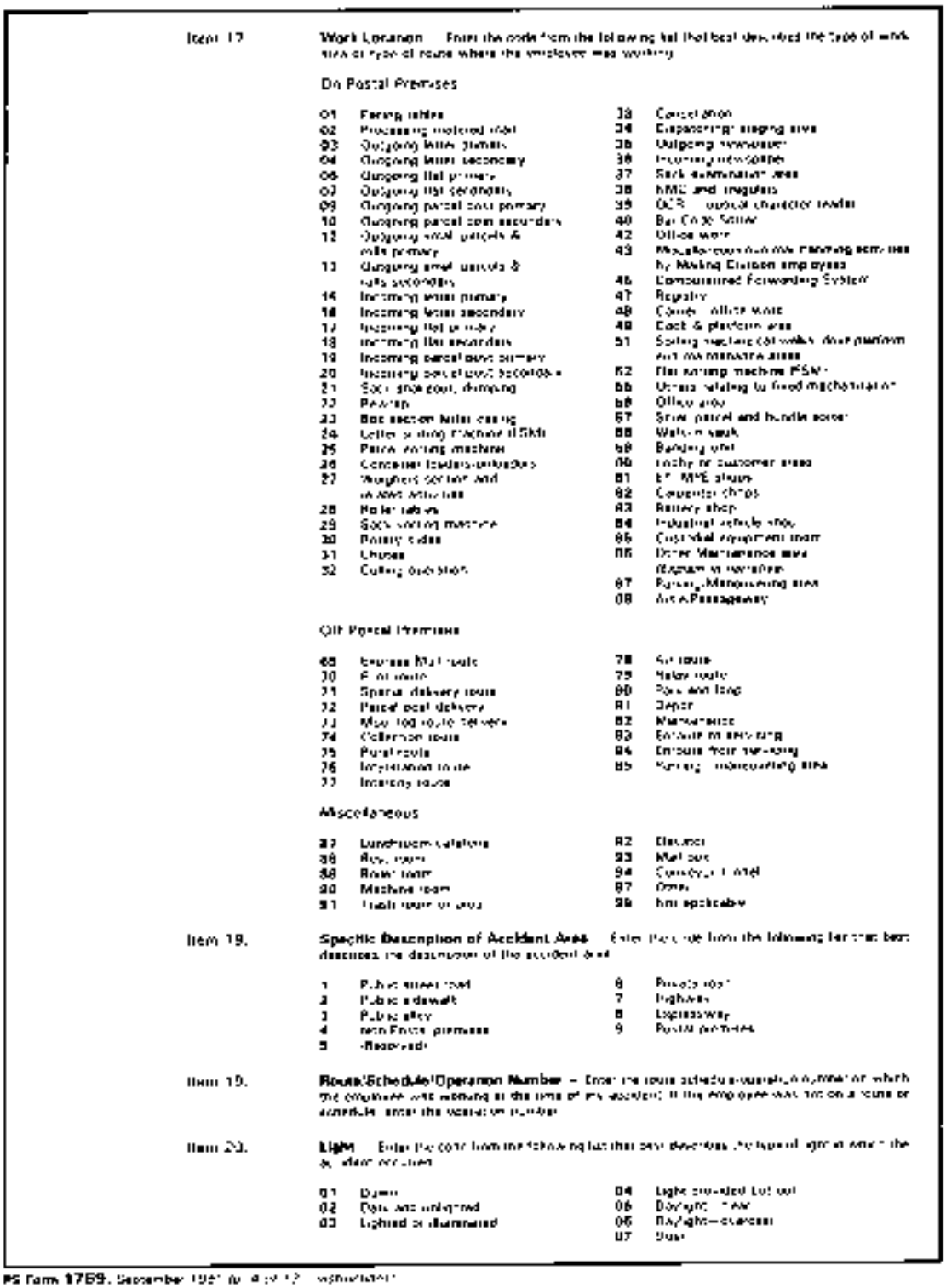
07 Division - Main Office
08 NSC - Main Office
10 Vehicle Maintenance Facility
11 Annex Facility
12 Regional Office
13 Headquarters Office
14 Postal Data Center
15 Supply Center
16 Mail Equipment Shop
18 Independent Mail Processing Center
20 Mail Bag Depositories and Pouch Centers
22 Railroad Terminal
23 Truck Terminal
24 U.S. Mail Center
26 Postal Training Facility
28 Other

Non-Postal

50 Other (explain in narrative)
51 Customer's building/premises
97 Other (explain in narrative)
99 Not applicable

PS Form 1769, September 1991 (p. 3 of 12) (reverse) (illegible)

Form 1769 (continued)



Item 17 **Work Location** — From the code from the following list that best describes the type of work area or type of route where the employee was working.

On Postal Premises

01	Facing tables	38	Consolidation
02	Processing manual mail	39	Dispatching/staging area
03	Outgoing letter primary	35	Outgoing secondary
04	Outgoing letter secondary	36	Incoming secondary
05	Outgoing flat primary	37	Sack examination area
07	Outgoing flat secondary	38	MMS and irregulars
09	Outgoing parcel post primary	39	OCR — output operator loader
10	Outgoing parcel post secondary	40	Bar Code Sorter
12	Outgoing small parcels & mail primary	42	Office work
13	Outgoing small parcels & mail secondary	43	Mail processing activities performed by Mailing Division employees
14	Incoming letter primary	45	Computerized Forwarding System
15	Incoming letter secondary	47	Repairs
17	Incoming flat primary	48	Carrier office work
18	Incoming flat secondary	49	Dock & platform area
19	Incoming parcel post primary	51	Sorting machine operations other than platform and maintenance areas
20	Incoming parcel post secondary	52	Flat sorting machine (FSM)
21	Sack shake-out, dumping	55	Manual labeling to fixed machine operation
23	Rewrap	56	Office area
23	Box section letter casing	57	Small parcel and bundle sorter
24	Letter sorting machine II Slot	58	Watch desk
25	Parcel sorting machine	59	Bedding unit
26	Container loaders-unloaders	60	Lobby or customer area
27	Weighing service and related activities	61	EF MPE steps
28	Roller tables	62	Carpenter shops
29	Sack sorting machine	63	Battery shop
30	Rotary tubs	64	Industrial vehicle shop
31	Chutes	65	Custodial equipment room
32	Cutting operation	66	Other Maintenance area (Explain in narrative)
		67	Parcel Manifesting area
		68	Aisle/Passageway

Off Postal Premises

69	Express Mail route	78	Air route
70	P.O. route	79	Relay route
71	Special delivery route	80	Pick and Ship
72	Parcel post delivery	81	Depot
73	Mail bag route delivery	82	Maintenance
74	Collection route	83	Enroute processing
75	Rural route	84	Enroute transferring
76	Inspection route	85	Mailing subcontracting area
77	Inventory route		

Miscellaneous

87	Lunchroom/cafeteria	92	Elevator
88	Rest room	93	Mail box
89	Break room	94	Conveyor belt
90	Machine room	97	Other
91	Training room or area	99	Not applicable

Item 18. **Specific Description of Accident Area** — Enter the code from the following list that best describes the description of the accident area.

1	Public street/road	6	Private road
2	Public sidewalk	7	Highway
3	Public alley	8	Expressway
4	Non-Postal premises	9	Postal premises
5	Reserved		

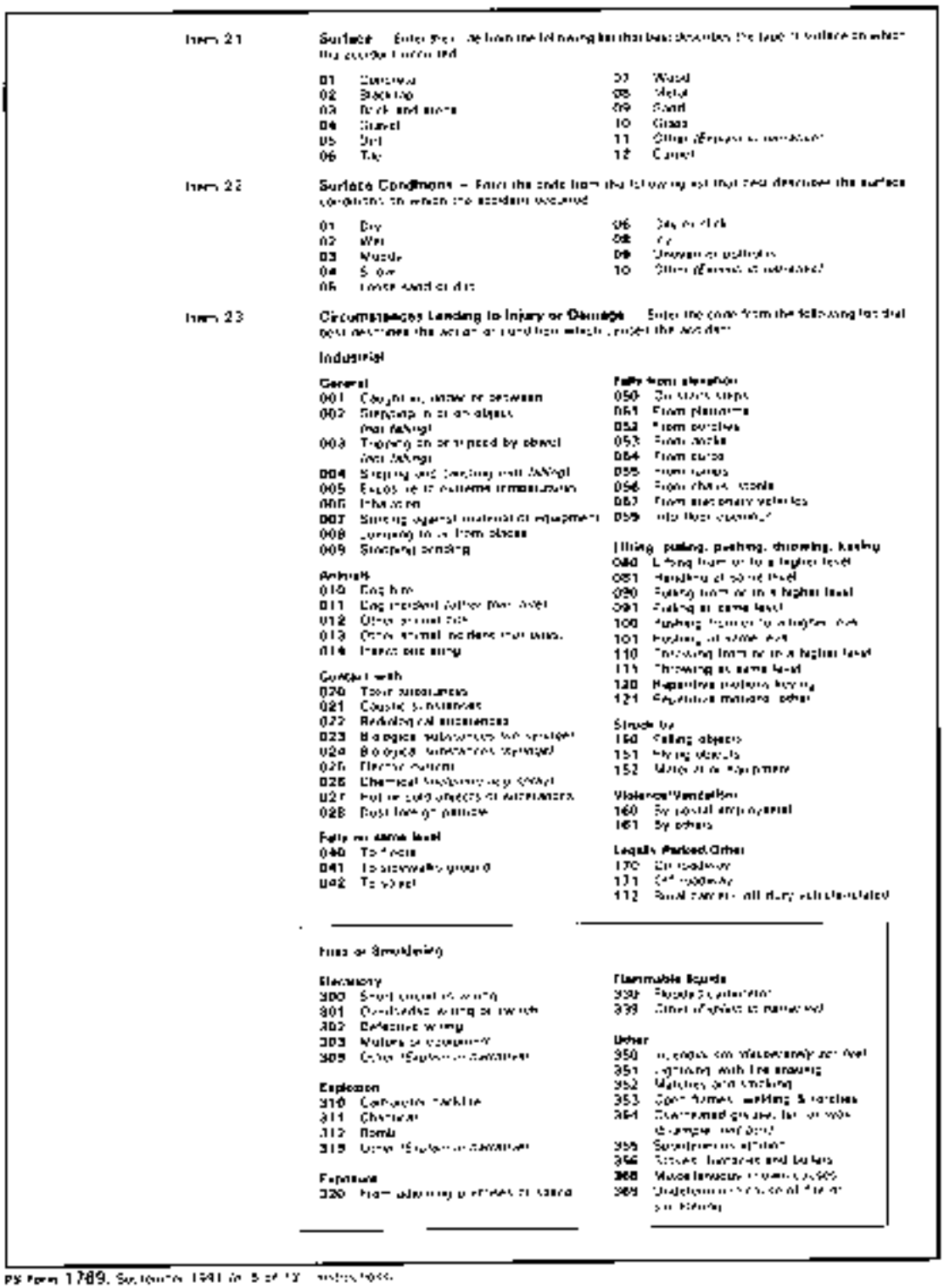
Item 19. **Route/Schedule/Operation Number** — Enter the route schedule/operation number on which the employee was working at the time of the accident. If the employee was not on a route or schedule, enter the nearest number.

Item 20. **Light** — Enter the code from the following list that best describes the type of light at the accident location.

01	Dawn	04	Lighted outdoor lot
02	Dark and unlighted	05	Daylight - TAW
03	Lighted or illuminated	06	Daylight - overcast
		07	Dusk

PS Form 1769, December 1987 (p. 2 of 2) (reverse)

Form 1769 (continued)



Item 21 **Surface** Enter the code from the following list that best describes the type of surface on which the accident occurred.

01	Concrete	07	Wood
02	Blacktop	08	Metal
03	Rock and stone	09	Sand
04	Gravel	10	Grass
05	Dirt	11	Other (Explain in narrative)
06	Tile	12	Carpet

Item 22 **Surface Conditions** – Enter the code from the following list that best describes the surface conditions on which the accident occurred.

01	Dry	06	Icy or slick
02	Wet	08	Ice
03	Muddy	09	Uneven or pothole
04	Snow	10	Other (Explain in narrative)
05	Loose sand or dirt		

Item 23 **Circumstances Leading to Injury or Damage** Enter the code from the following list that best describes the action or condition which caused the accident.

Industrial

General
001 Caught in, under or between
002 Stepping on or on objects (not falling)
003 Tripping on or stepped by object (not falling)
004 Slipping and tripping (not falling)
005 Exposure to extreme temperature
006 Inhalation
007 Striking against material or equipment
008 Jumping to or from places
009 Stepping, pinching

Animals
010 Dog bite
011 Dog involved (other than bite)
012 Other animal bite
013 Other animal actions (not bite)
014 Insect bite, sting

Contact with
020 Toxic substances
021 Caustic substances
022 Radiating substances
023 Biological substances (not specified)
024 Biological substances (specified)
025 Electric current
026 Chemical substances (not specified)
027 Hot or cold objects or substances
028 Dust (except poison)

Fully or same level
040 To floor
041 To accessible ground
042 To vessel

Falls from elevation
050 On stairs, steps
051 From platforms
052 From scaffolds
053 From ladder
054 From curbs
055 From ramps
056 From chairs, stools
057 From stationary vehicles
059 Other (Explain in narrative)

Lifting, pulling, pushing, throwing, kicking
080 Lifting from or to a higher level
081 Handling at same level
090 Pulling from or to a higher level
091 Pulling at same level
100 Pushing from or to a higher level
101 Pushing at same level
110 Throwing from or to a higher level
111 Throwing at same level
120 Repetitive motions, kicking
121 Repetitive motions, other

Struck by
150 Falling objects
151 Flying objects
152 Moving parts of equipment

Violence/Vandalism
160 By co-worker, employee
161 By others

Legally Related/Other
170 On roadway
171 Off roadway
172 Road rage – all duty vehicle related

Fires or Explosions

Electricity
300 Short circuit or arcing
301 Overloaded wiring or switch
302 Defective wiring
303 Failure of equipment
309 Other (Explain in narrative)

Explosion
310 Combustible mixture
311 Chemical
312 Bomb
319 Other (Explain in narrative)

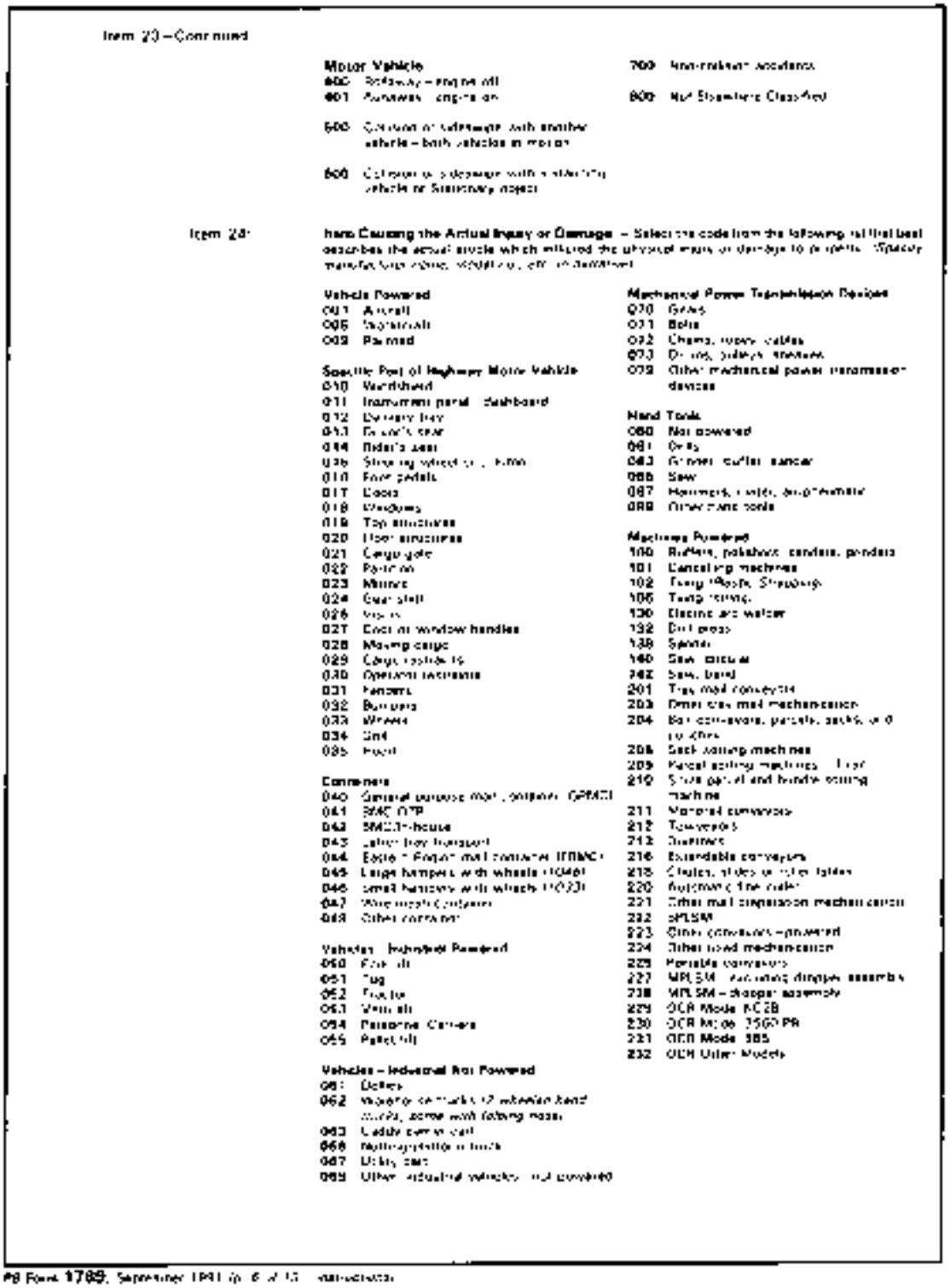
Fixtures
320 Fixed object or structure

Flammable liquids
330 Flooded carburetor
339 Other (Explain in narrative)

Other
350 Engine on excessively or fuel
351 Ignition with fire arsonist
352 Matches and smoking
353 Cooking, welding & torches
354 Overheated grease, fat or oil (Example: roof fire)
355 Spontaneous ignition
356 Stoves, furnaces and boilers
358 Miscellaneous (Explain in narrative)
359 Undetermined (Explain in narrative)

PS Form 1769, September 1991 (Reverse) (7530-02-000-9999)

Form 1769 (continued)



Item 23—Continued

Motor Vehicle
- 400 Roadway – engine off
- 401 Roadway – engine on
- 500 Collision or sideswipe with another vehicle – both vehicles in motion
- 600 Collision or damage with a stationary vehicle or stationary object
- 700 Non-motor vehicle accident
- 800 Not Elsewhere Classified

Item 24: **Item Causing the Actual Injury or Damage** – Select the code from the following list that best describes the actual article which inflicted the physical injury or damage to property. (Specify manufacturer name, model no., etc. if available)

Vehicle Powered
- 001 Aircraft
- 005 Watercraft
- 009 Railroad

Specific Part of Highway Motor Vehicle
- 010 Windshield
- 011 Instrument panel – dashboard
- 012 Driver's door
- 013 Driver's seat
- 014 Rider's seat
- 016 Steering wheel or bars
- 016 Floor pedals
- 017 Doors
- 018 Windows
- 019 Top structures
- 020 Other structures
- 021 Cargo gate
- 022 Ramp
- 023 Mirror
- 024 Gear shift
- 026 Visor
- 027 Door or window handles
- 028 Moving cargo
- 029 Cargo restraints
- 030 Optional accessories
- 031 Fenders
- 032 Bumpers
- 033 Wheels
- 034 Tire
- 035 Hood

Conveyors
- 040 General purpose mat, polyurethane (PPMC)
- 041 SMC OTP
- 042 SMC In-house
- 043 Labor tray transport
- 044 Eagle – Fogarty mat conveyor (EMMC)
- 045 Large hampers with wheels (LHW)
- 046 Small hampers with wheels (SHW)
- 047 Wire mesh conveyor
- 049 Other conveyor

Vehicles – Industrial Powered
- 050 Fork lift
- 051 Tug
- 052 Tractor
- 053 Van lift
- 054 Personnel Carriers
- 055 Pallet lift

Vehicles – Industrial Not Powered
- 061 Dollies
- 062 Majority of carts (2 wheeler hand trucks, some with folding nose)
- 063 Caddy carrier cart
- 066 Multi-wheeled cart
- 067 Utility cart
- 069 Other industrial vehicles not covered

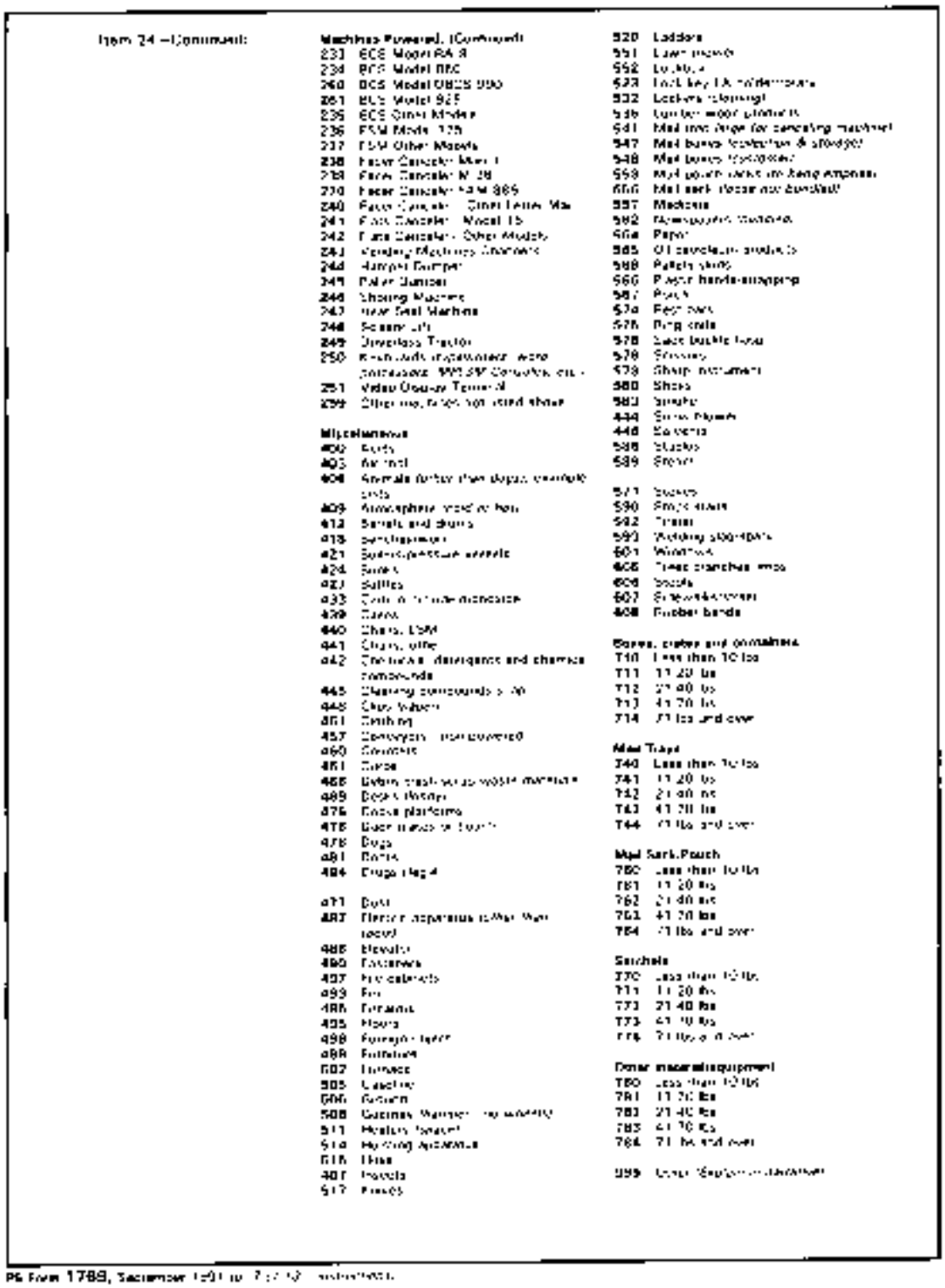
Mechanical Power Transmission Devices
- 070 Gears
- 071 Belts
- 072 Chains, roller, cables
- 073 Drive, pulleys, sheaves
- 079 Other mechanical power transmission devices

Hand Tools
- 080 Not powered
- 081 Drills
- 083 Grinder, cutter, sander
- 086 Saw
- 087 Hammers, mallet, sledge/maul
- 089 Other hand tools

Machinery Powered
- 100 Rollers, polishers, sanders, grinders
- 101 Cleaning machines
- 102 Temp Wheels, Strapping
- 105 Temp forms
- 130 Electric arc welder
- 132 Drill press
- 138 Sprue
- 140 Saw, circular
- 142 Saw, band
- 201 Tray mat conveyor
- 203 Other tray mat mechanization
- 204 Box conveyors, parcels, sacks, or totes
- 206 Sack sewing machines
- 209 Parcel sealing machines – Tape
- 210 Strap panel and handle sealing machine
- 211 Monorail conveyors
- 212 Tow veyors
- 213 Overhead
- 216 Extendable conveyors
- 218 Chutes, slides or roller tables
- 220 Automatic tire cutter
- 221 Other mail compression mechanization
- 222 SPLSM
- 223 Other conveyors – powered
- 224 Other hand mechanization
- 225 Portable conveyors
- 227 MPLSM – vacuuming display assembly
- 228 MPLSM – stacker assembly
- 229 OCR Mode AC2B
- 230 OCR Mode 150 PR
- 231 OCR Mode 885
- 232 OCR Other Models

PS Form **1769**, September 1991 (p. 6 of 6) (Reverse)

Form 1769 (continued)



Item 24 —(Continued):

Machines Powered: (Continued)
231 ECS Model RA II
234 ECS Model RC
240 ECS Model OBCS 950
261 ECS Model 925
235 ECS Quad Binder
236 FSM Mode 125
237 FSM Other Models
238 Face Cancels: Mod I
239 Face Cancels: M 28
230 Face Cancels: FSM 885
240 Face Cancels: Other Letter Mo
241 Face Cancels: Model 15
242 Face Cancels: Other Models
243 Keying Machines (Numeric
244 Hamper Dumper
245 Paper Dumper
246 Shoving Machine
247 Hand Seal Machine
248 Scissor Lift
249 Driverless Tractor
250 Mail-handling equipment: wire
containers, MMS/SPC Consoles, etc.
251 Video Display Terminal
299 Other machines not listed above

Miscellaneous
402 Acids
403 Air tool
404 Animals (other than dogs, example
cats)
409 Atmosphere: wood or hay
412 Barrels and drums
413 Belts/suspenders
421 Boilers/pressure vessels
424 Bones
427 Bottles
433 Cable or wire manufacture
439 Cans
440 Chains, USM
441 Chairs, office
442 Chemicals: detergence and chemica
compounds
445 Cleaning compounds > 20
446 Clay tablets
451 Cloth(s)
457 Conveyors: non-powered
460 Concrete
461 Curbs
466 Debris: trash, scrap, waste materials
469 Desks (Metal)
476 Docks, platforms
478 Door frames or doors
479 Dogs
481 Dolls
484 Drugs (legal

491 Dust
497 Electric apparatus (Mail Han
recei)
498 Elevator
499 Excavation
497 Fire extinguish
499 Fire
499 Firearms
495 Floors
498 Foreign object
498 Furniture
502 Furnace
505 Gasoline
506 Gutters
508 Gutters, Warning - no warning
511 Heaters (space)
514 Hoisting Apparatus
515 Ilines
497 Insects
517 Knives

520 Ladders
551 Lawn mower
552 Locks
523 Lock key (A, collection
532 Lockers (closing)
536 Lumber, wood products
541 Mail inspection for canceling machine
547 Mail boxes (collection & street)
548 Mail boxes (curbside)
559 Mail pouch racks on Jeep wagons
566 Mail sack (secure and conduct)
557 Machine
562 Manhole covers
564 Paper
565 Oil (petroleum products)
568 Pallet jacks
560 Paper handling
567 Pens
570 Pen nibs
575 Pipe rails
578 Seat belts (use
579 Scissors
579 Sharp instrument
580 Shoes
582 Spirits
444 Stairs (open)
446 Solvents
586 Stacks
589 Stairs

571 Stairs
590 Step(s) (stair)
592 Trees
593 Welding apparatus
601 Wheelchair
605 Trees (branches, wood
606 Wood
607 Screwdrivers
608 Rubber bands

Boxes, crates and containers
T10 Less than 10 lbs
T11 11-20 lbs
T12 21-40 lbs
T13 41-70 lbs
T14 71 lbs and over

Mail Trays
T40 Less than 10 lbs
T41 11-20 lbs
T42 21-40 lbs
T43 41-70 lbs
T44 71 lbs and over

Mail Sack,Pouch
T60 Less than 10 lbs
T61 11-20 lbs
T62 21-40 lbs
T63 41-70 lbs
T64 71 lbs and over

Satchels
T70 Less than 10 lbs
T71 11-20 lbs
T72 21-40 lbs
T73 41-70 lbs
T74 71 lbs and over

Other mail equipment
T80 Less than 10 lbs
T81 11-20 lbs
T82 21-40 lbs
T83 41-70 lbs
T84 71 lbs and over

999 Other (Explain in narrative)

PS Form 1769, September 1991 to 7 [illegible]

Form 1769 (continued)

Item 25. **Hazardous Situation Directly Related to Accident** – Enter the code from the following list that best describes hazardous situation directly related to the accident.

01	Inadequate aisle or working space	29	Faulty construction
02	Congested or blocked area	30	Improper equipment design
03	Improper storage method	31	Faulty job training
04	Poor drainage	32	Improper assignment of personnel
05	Unsafe fire warning condition/ device supplied	33	Lack of or inadequate job procedures
06	Insufficient electrical outlets	34	Lack of or inadequate safety rules
07	Inadequately guarded equipment	35	Lack of knowledge or skill
08	Absence of hand rails on steps or ramps	51	Sight obstruction
09	Poor housekeeping (slippery and obstructed)	53	Improperly loaded equipment or vehicle
10	Unsafe planning, process or operational methods	62	Absence of maintenance platforms
11	Improper or insufficient lighting	63	Inadequate or insufficient nip-point guards or gear guards
12	Lack of emergency lighting	65	Absence of or inadequate cage enclosure, warning or access interlock switches
13	Dangerous arrangement of loading area, storage or bin location etc.	67	Absence of or inadequate emergency pull cords or stop buttons
14	Excessive noise	69	Improperly located or inaccessible emergency pull cords or stop buttons
15	Platforms too high or too low	70	Other hazardous situations relating to mechanized equipment
16	Lack of personal protective equipment	97	Other hazardous situation (Explain in narrative)
17	Absence of steps to get from platform	98	No hazardous situations
18	Improper ventilation		
19	Excessive exposure to fumes		
20	Hazardous conditions of customer's premises		
21	Slippery or wet floor surface		
22	Unprotected pit or hole		
23	Overhead equipment		

Item 26. **Defective or Hazardous Equipment or Material Related to Accident** – Enter the code from the following list that best describes hazardous equipment or material that was related to the accident.

Motor Vehicle		**Industrial**	
01	Defective accelerator	40	Short circuit or wiring
02	Defective clutch	41	Defective or overloaded wire or switch
03	Defective foot brakes	42	Defective grounds or connectors
04	Defective hand brakes	50	Sharp edges on equipment and furniture
05	Defective horn	51	Defective sling chain
06	Defective springs or suspension system	52	Ragged or rusty metal pieces
07	Defective or dirty windshield	53	Defective rotation parts
08	Defective windshield wipers	54	Defective pedal stairsteps
09	Defective or poorly adjusted mirrors	55	Defective customer stairs/steps or porches
10	Defective steering system	56	Slippery floor surface
11	Defective safety glass	57	Rough, slippery or broken walking surfaces
12	Defective seat	58	Loose material on surface
13	Defective safety belts	60	Negligence of other safety observance
15	Defective headlights	61	Malfunction of emergency pull cords or stop buttons
16	Defective operating lights	69	Malfunction of other safety equipment
17	Defective stop brake lights	64	Defective latches – mail containers receptacles
18	Defective wheels		
20	Smooth or worn tires	**Industrial Powered Vehicles**	
21	Loose wheel attachments	65	Defective shift selector
22	Motor failure	66	Defective brakes
23	Poor stability (vehicle)		
24	Restricted view (part of vehicle design)	**Other**	
26	Defective wiring	97	Other defects (Explain in narrative)
27	Defective shift selector	98	No defects or hazardous equipment or material

Item 27 **Total Number of Vehicles** – Enter the total number of vehicles involved in the accident.

Item 28 **Reserved.**

PS Form 1769, September 1991 (S of 2) – (reverse)

Form 1769 (continued)

Item 29: **Vehicle Type** — For [illegible] vehicles enter the make, model, and [illegible] vehicles. For the most recent Postal Vehicle Service Publication. Be sure to use all 4 digits.

If the accident involved non-postal vehicles, enter a code from the following list:

0091 Contract
0092 Leased
0093 Rental — Short-term agreements
0094 Private — Non-contract (POV)
0095 GSA
0096 Private — Non-contract (POV)
0098 Other vehicles used on official Postal activities
0099 All others — Non-USPS

Item 30: **Vehicle Path** — Enter the code from the following list that best describes the movement of the vehicle immediately preceding the accident.

01 Straight ahead
02 Left turn
03 Right turn
04 U-turn right
05 U-turn left
06 Passing
07 Lane change
08 Backing
09 Skidding
10 Stopped
11 Standing
12 Jackknifing
13 Running off road
14 Pulling to curb/mailbox
15 Pulling from curb/mailbox
16 Unattended vehicle moving
17 Unattended vehicle stopped
18 Legally parked
19 Steering curve
20 Changing lane
97 Other (explain in narrative)
98 Not applicable

Items 31-33. **Self explanatory**

Item 34 **Initial Area of Impact**

Passenger Cars, Jeeps, LLVs, Trucks (Excluding 5 & 6 Ton Trucks & Tractor Trailers

01 Front end
02 Right front side
03 Left front side
04 Right occupant side
05 Left occupant side
06 Right rear side
07 Left rear side
08 Rear end
09 Top structure
10 Undercarriage

5 Ton or Larger Trucks and Tractor Trailers ONLY

11 Front end
12 Right front side
13 Left front side
14 Right occupant side
15 Left occupant side
16 Right rear cargo side
17 Left rear cargo side
18 Right rear cargo side
19 Left rear cargo side
20 Rear end
21 Top structure
22 Undercarriage
97 Other (explain in narrative)
98 Not applicable

Items 35 & 36. **Reserved**

Item 37 **Total No. of Accident Reports** — One form must be submitted for each person injured. See "Motor Vehicle Accidents" [illegible] of Instructions.

Item 38 **Person Identification No.** — If more than one person was injured in the accident enter "1". For each additional injured person, complete an additional 1769 form and enter consecutive numbers. See "Motor Vehicle Accidents" [illegible] of Instructions.

Item 39 **Self explanatory**

Item 40. **Name** — Name of person involved in accident.

Item 41: **Age** — If the person was a non-postal person, enter their age at the time of the accident.

Item 42 **Self-explanatory**

Item 43. **Designation and Activity** — Enter the 3 digit OPS #21 code for the employee's tour and station. For non-postal, enter one of the codes below:

001 Customer or general public
002 Non-postal Government Activities

Item 44: **Injury/Illness Severity** — Enter the code from the following list that best describes the type of injury or illness experienced by the person identified in item 40 of this form.

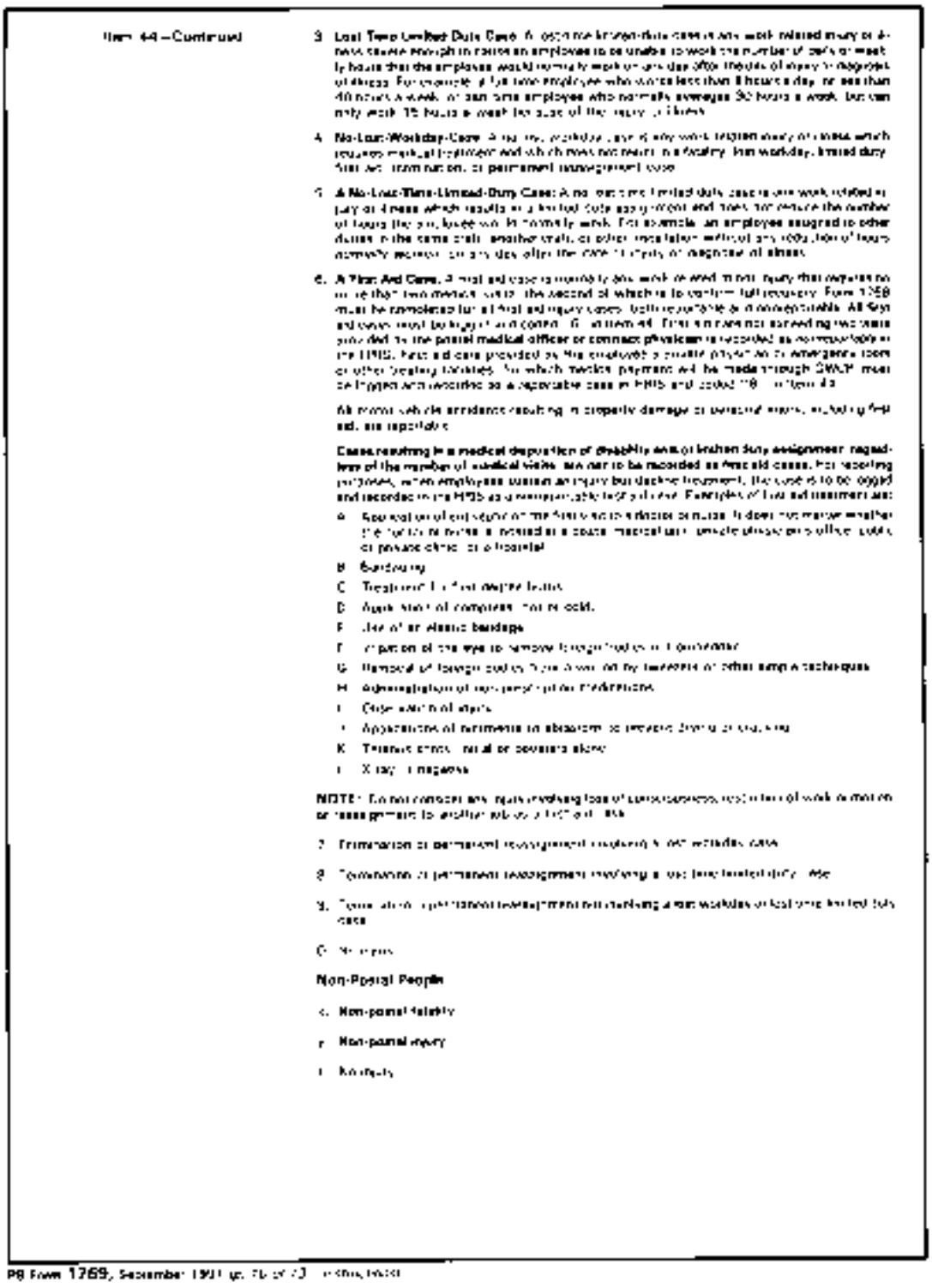
Postal Employees:

1. **Fatality** — A fatality is any work related injury or illness which results in death, regardless of the time between the injury and death, or length of illness. If death occurs after submission of an Accident Report, you must change the severity code in the HRIS.

2. **Lost Workday Case** — A lost workday case includes more than a work related injury or illness which is severe enough to render an employee unable to perform any duties on any workday or workdays subsequent to the day of injury or diagnosis of illness during which the employee would have worked but could not because of the nature of illness.

PS Form 1769, December 1991 (p. 2 of 3) - continued

Form 1769 (continued)



Item 44—Continued

3 **Lost Time-Limited Duty Case.** A nonfatal lost-time case in which work related injury or illness causes enough incapacity to render an employee to be unable to work the number of days or meet the hours that the employee would normally work on any day after the date of injury or beginning of illness. For example, if full time employee who normally works less than 8 hours a day or less than 40 hours a week, or part time employee who normally averages 30 hours a week, but can only work 15 hours a week because of the injury or illness

4 **No-Lost-Workday Case.** A nonfatal case of any work related injury or illness which requires medical treatment and which does not result in a fatality, lost workday, limited duty assignment, or permanent reassignment case

5 **A No-Lost-Time-Limited-Duty Case.** A nonfatal limited duty case is one work related injury or illness which results in a limited duty assignment and does not involve the number of hours the employee would normally work. For example, an employee assigned to other duties in the same shift, another shift, or other regularly scheduled days or hours normally worked on any day after the date of injury or beginning of illness

6 **A First Aid Case.** A nonfatal case involving only work related injury that requires no more than one medical visit, the second of which is routine follow-up recovery. Form 1958 must be completed for all first aid injury cases. Both recordable & nonrecordable. All first aid cases must be logged and coded. Examples of first aid cases not requiring medical visit to the postal medical officer or contract physician is recorded as nonrecordable in the HRIS. First aid care provided by the employee's private physician or emergency room or other treating facilities for which medical payment will be made through CWAP must be logged and recorded as a reportable case in HRIS and coded "6" in Item 43

All motor vehicle accidents resulting in property damage or personal injury, including first aid, are reportable

Cases resulting in a medical deposition of disability and/or limited duty assignment regardless of the number of medical visits are not to be recorded as first aid cases. For recording purposes, when employees sustain an injury but decline treatment, the case is to be logged and recorded in the HRIS as a reportable injury or illness. Examples of first aid treatment are:

A Application of antiseptic or treatment of first degree burns. It does not matter whether the injury is minor and treated at a postal medical unit, private physician's office, clinic or private clinic or a hospital

B Bandaging

C Treatment of first degree burns

D Application of compress, hot or cold.

E Use of an elastic bandage

F Irrigation of the eye to remove foreign matter or chemicals

G Removal of foreign bodies from the eye by tweezers or other simple techniques

H Administration of non-prescription medications

I Cleaning and dressing

J Application of ointments to abrasions or minor burns or scratches

K Tetanus shots, oral or parenteral alone

L X-ray - negative

NOTE: Do not consider any injury involving loss of consciousness, restriction of work or motion or transfer to another job as first aid. Rule

7 Termination of permanent reassignment (explain) (Use with Middle Digit)

8 Termination of permanent reassignment involving a lost time limited duty case

9 Termination of permanent reassignment involving a non-workday or lost time limited duty case

0 No injury

Non-Postal People

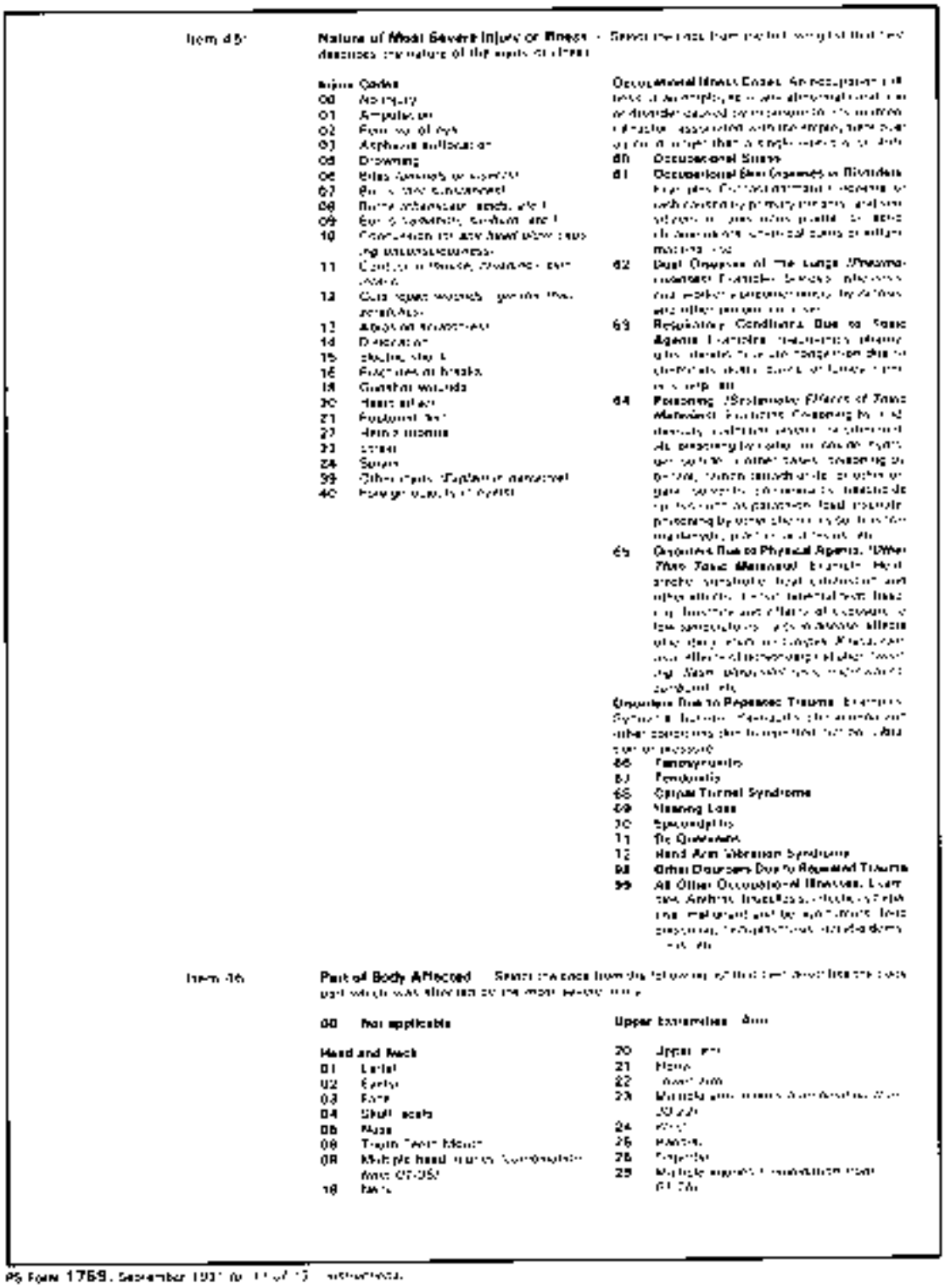
c Non-postal fatality

r Non-postal injury

t Non-injury

PS Form 1769, September 1991 (p. 2 of 2) (Reverse)

Form 1769 (continued)



Item 45 **Nature of Most Severe Injury or Illness** - Select the one item from the list below that best describes the nature of the most severe injury or illness.

Injury Codes

00 Not Injury
01 Amputation
02 Eye injury or loss of eye
03 Asphyxia suffocation or strangulation
04 Drowning
05 Bites (animal or human)
07 Burn or scald (chemical)
08 Burns (thermal or unspecified)
09 Effects of electricity, lightning, and radiation
10 Concussion or any head injury (excluding internal injuries)
11 Crushing or bruising (including cuts and abrasions)
12 Cuts (open wounds - penetrating injuries and abrasions)
13 Effects of temperature
14 Dislocation
15 Sprains, strains
16 Fractures or breaks
18 Guns/shot wounds
20 Heart attack
21 Poisoning, oral
22 Animal injuries
23 Stroke
24 Stings
99 Other injuries (Explain in narrative)
40 Foreign body in eye(s)

Occupational Illness Codes An occupational illness is any abnormal condition or disorder caused by exposure to environmental factors associated with employment, other than one resulting from an injury.

60 **Occupational Stress**
61 **Occupational Skin Diseases or Disorders** Examples: Contact dermatitis caused by primary irritants and sensitizers or poisons (such as poison ivy, poison oak, poison sumac and poison hemlock); chemical burns or inflammations
62 **Dust Diseases of the Lungs (Pneumoconioses)** Examples: Silicosis, asbestosis and other pneumoconioses caused by inhalation of dust; inflammation of the lungs
63 **Respiratory Conditions Due to Toxic Agents** Examples: Pneumonitis, pharyngitis, rhinitis or acute congestion due to chemicals, dusts, gases or fumes; farmer's lung
64 **Poisoning (Systemic Effects of Toxic Materials)** Examples: Poisoning by lead, mercury, cadmium, arsenic or other metals; poisoning by carbon monoxide, hydrogen sulfide or other gases; poisoning by benzene, carbon tetrachloride, other organic solvents; poisoning by insecticide sprays such as parathion, lead arsenate; poisoning by other chemicals such as formaldehyde, plastics and resins
65 **Disorders Due to Physical Agents (Other Than Toxic Materials)** Examples: Heat prostration; sunstroke; heat exhaustion and other effects of environmental heat; freezing, frostbite and effects of exposure to low temperatures; caisson disease; effects of ionizing radiation (isotopes, X-rays, atomic radiation); effects of nonionizing radiation (welding flash, ultraviolet rays, microwaves, sunburn), etc.

Disorders Due to Repeated Trauma Examples: Carpal tunnel syndrome; noise-induced hearing loss; synovitis, tenosynovitis and other conditions due to repeated motion, vibration or pressure

66 Tendonitis
67 Tenosynovitis
68 Carpal Tunnel Syndrome
69 Hearing Loss
70 Sacroiliitis
71 De Quervain's
72 Hand Arm Vibration Syndrome
98 Other Disorders Due to Repeated Trauma
99 All Other Occupational Illnesses. Examples: Anthrax, brucellosis, infectious hepatitis, malignant and benign tumors, food poisoning, histoplasmosis, coccidioidomycosis, etc.

Item 46 **Part of Body Affected** - Select the one item from the following list that best describes the part of the body that was affected by the most severe injury or illness.

00 **Not applicable**

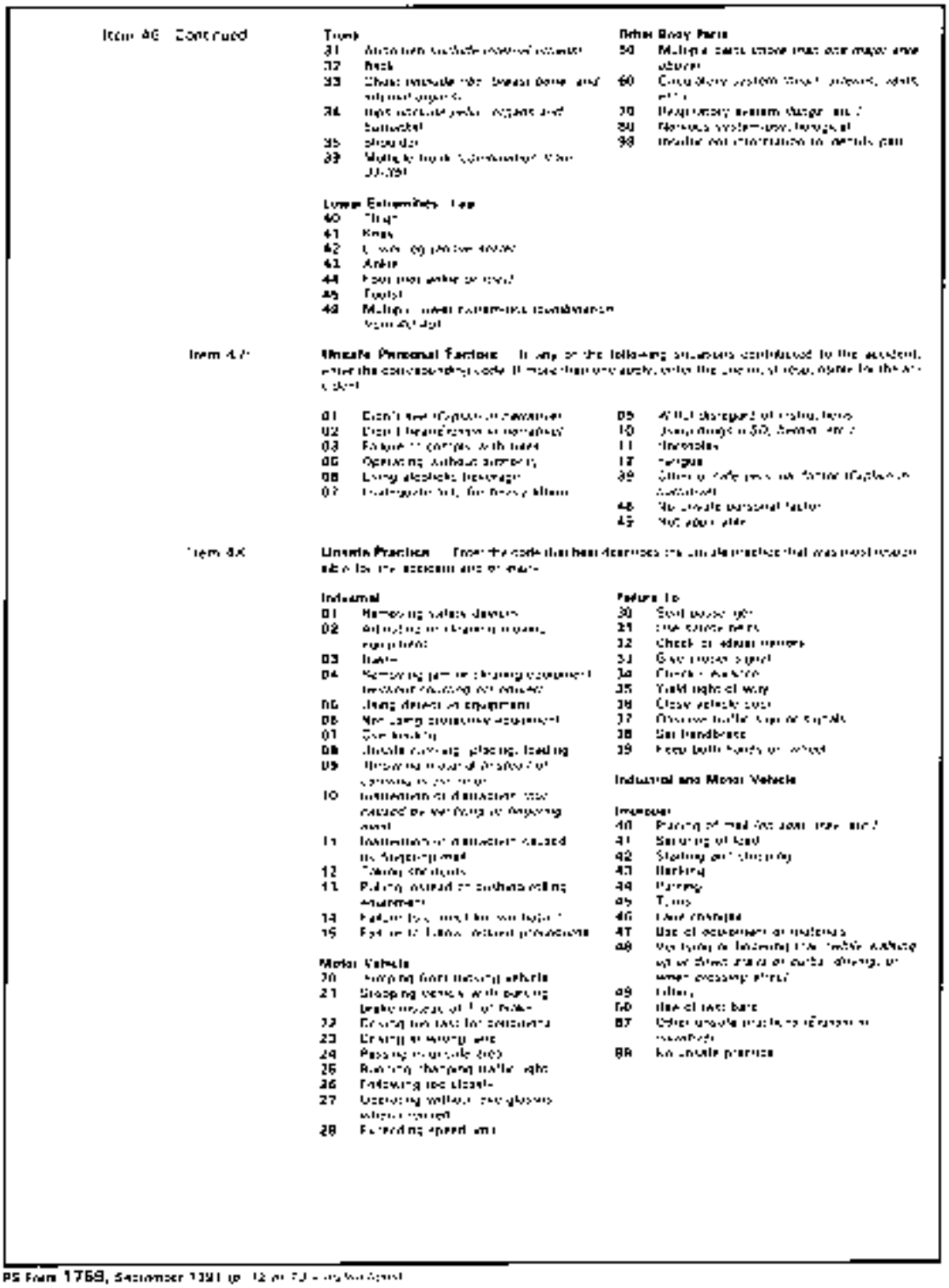
Head and Neck
01 Head
02 Eye(s)
03 Face
04 Skull, scalp
05 Nose
06 Teeth, mouth
08 Multiple head injuries (combination of codes 01-05)
10 Neck

Upper Extremities - Arm

20 Upper arm
21 Elbow
22 Lower arm
23 Wrist(s), including carpal tunnel syndrome
24 Hand(s)
25 Finger(s)
26 Fingertip(s)
28 Multiple upper extremities (combination of codes 20-26)

PS Form 1769, September 1995 (S/N 7540-00-934-9052)

Form 1769 (continued)



Item 46 Continued

Trunk
31 Abdomen (include internal organs)
32 Back
33 Chest (include rib, breast bone, and internal organs)
34 Hip, socket, pelvic region, and buttocks
35 Shoulder
39 Multiple trunk injuries (combination of 31-35)

Lower Extremities, Leg
40 Thigh
41 Knee
42 Leg (not ankle or knee)
43 Ankle
44 Foot (not ankle or toes)
45 Toe(s)
49 Multiple lower extremities (combination of 40-45)

Other Body Parts
50 Multiple parts above (not combination of 39, 49, 59, 69, or 79)
60 Circulatory system (heart, internal organs, blood, etc.)
70 Respiratory system (lungs, etc.)
80 Nervous system (brain, nerves, etc.)
98 Injuries not classifiable to above parts

Item 47 **Unsafe Personal Factors** Identify any of the following circumstances contributed to the accident, enter the corresponding code. If more than one apply, enter the one most relevant to the accident.

01 Didn't see (failure to perceive)
02 Didn't hear (failure to perceive)
03 Failure to comply with rules
06 Operating without authority
08 Using alcoholic beverage
07 Inadequate skill for heavy lifting
09 Acted improperly (horseplay, etc.)
10 Inattention or distraction (not caused by working or playing too fast)
11 Intimidated
12 Fatigue
39 Other unsafe personal factors (explain in narrative)
48 No unsafe personal factor
49 Not applicable

Item 48 **Unsafe Practice** From the code that best describes the unsafe practice that was most responsible for the accident and enter it here.

Industrial
01 Removing safety devices
02 Adjusting or cleaning moving equipment
03 Haste
04 Removing jam or cleaning equipment (without shutting off power)
05 Using defective equipment
06 Not using protective equipment
07 Overloading
08 Unsafe conveying, placing, loading
09 Throwing instead of placing (not covered by working or playing too fast)
10 Inattention or distraction (not caused by working or playing too fast)
11 Intimidation or distraction caused by fellow employee
12 Taking shortcuts
13 Failure to secure or authorize safety equipment
14 Failure to warn (not horseplay)
15 Failure to follow safety procedures

Motor Vehicle
20 Jumping from moving vehicle
21 Stopping vehicle with parking brake released or not set
22 Driving too fast for conditions
23 Driving in wrong lane
24 Passing in unsafe area
25 Running stop sign or traffic light
26 Following too closely
27 Operating without required lights or signals
28 Exceeding speed limit

Failure To
30 Yield right of way
31 Use crosswalk
32 Check or adjust brakes
33 Give proper signal
34 Check clearance
35 Yield right of way
36 Obey safety rule
37 Observe traffic sign or signals
38 Use handbrake
39 Keep both hands on wheel

Industrial and Motor Vehicle

Improper
40 Parking or road (not work) vehicle
41 Securing of load
42 Starting or stopping
43 Backing
44 Turning
45 Turns
46 Lane changes
47 Use of equipment or materials
48 Working in hazardous (for motor vehicle) way or other unsafe or careless driving, or when crossing street
49 Riding
50 Use of seat belt
87 Other unsafe practices (explain in narrative)
88 No unsafe practice

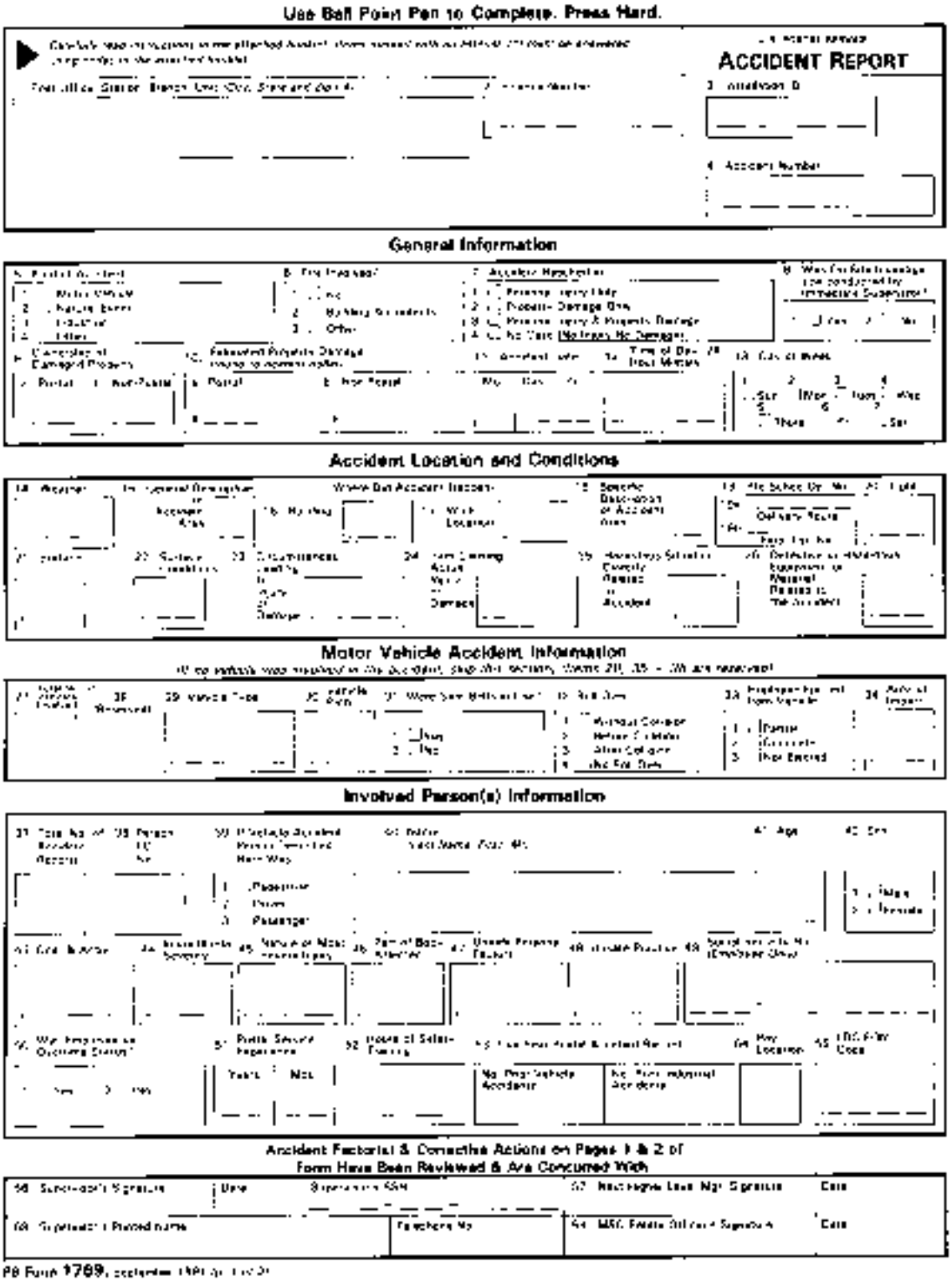
PS Form 1769, September 1991 (p. 2 of 2) [illegible]

Form 1769 (continued)

Item 49	**Social Security Number** — Enter the employee's social security number. Do not enter zeros or dashes.
Item 50	**Was Employee on Overtime Status?** — Check one.
Item 51	**Postal Service** — Enter the employee's years in the Postal Service to the nearest whole month using only the numbers. For example, enter 1 year 6 months and 10 days as 1.06.
Item 52	**Hours of Safety Training** — Enter hours of safety training employee received within the last five years as recorded on PS Form 3545 or other available records.
Item 53	**Self-explanatory.**
Item 54.	**Pay Location** — Enter the pay location of the employee at the time of the accident. If not applicable, enter "000."
Item 55.	**LDC/FDN Code** — Enter the LDC Code of the employee at the time of the accident. If not available, enter "000." When in doubt, refer to the LDC Code Directory for assistance. **NOTE:** You must enter a LDC Code or "000." If you do not, the 1769 will be returned. At a future date, instructions will be provided concerning the replacement of the LDC code with the 4-digit FDN Code.
Items 56–59	**Self explanatory.**
Item 60.	**Is a USA Postal Service Form 1783, On-the-Job Safety Review/Analysis, On File?** — Indicate whether an analysis exists for the activity being performed at the time of the accident.
Item 61.	**Preventive Action Code** — Enter the code from the following list that best describes the action you will take to most effectively eliminate or reduce the accident hazard and prevent similar accidents. 01 Provide training instruction to ensure that employee understands established procedures and will recognize similar hazards in unsafe practices in the future. 02 Establish proper job procedure for task to be performed. 04 Simplify established job procedures if complex or unsafe. 05 Ensure that employee has the knowledge to perform task. 06 Motivate employee to properly perform task. 07 Revise work order. 08 Provide adequate hazard warning signs or devices. 09 Initiate action to determine if employee meets physical requirements of the job. 10 Report discipline proposed. 11 Evaluate employee supervision. 12 Initiate action to improve correct work equipment or layout design. 13 Initiate action to improve routine equipment maintenance and cleanliness/housekeeping. 14 Ensure availability of and/or provide proper protective equipment, materials or tools. 15 Other (Explain in narrative). 16 Notify special postal authorities. 99 Not applicable.
Instructions for Narrative	**Complete the narrative first and provide the information listed below. This will make it easier to select the proper codes.** Be specific and provide as much detail as possible when completing the narrative. Describe the specific activity when the employee was performing immediately prior to the accident. Indicate whether the activity was being properly performed. Indicate whether or not the employee was aware of a hazard and can clearly be exactly what he/she was doing at that time. Describe the employee's reaction to avoid the hazard. If any, Specifically describe the interaction between the employee and the hazard which caused the injury or incident. Do not describe the result, eg, injury or property damage.
Hospital/Physician Information	If the accident injury is such that it is the employee's responsibility to report to the employer, provide the name of the hospital and/or physician's medical facility, address and phone number. Additionally, provide the date the employee received medical treatment and the first scheduled work day.
Hazardous Conditions, and/or Equipment, Materials, Etc	If any condition being cited of the accident was due to hazardous conditions and/or equipment or materials, do not the manufacturer's name, model, or other identification such as the serial number of the equipment or material involved in the accident.
Vehicle Diagram	If the accident involved a motor vehicle, use the diagram on page 2 to graphically describe the accident. Show the direction of each vehicle involved, point of impact with other vehicles or objects, and use items 1 through 11 of the section, as appropriate, to indicate what happened.

PS Form 1769, September 1991 (p. 2 of 2) (reverse side)

Form 1769


Use Ball Point Pen to Complete. Press Hard.
ACCIDENT REPORT
General Information
Accident Location and Conditions
Motor Vehicle Accident Information
Involved Person(s) Information
Accident Factors/& Corrective Actions on Pages 1 & 2 of
Form Have Been Reviewed & Are Concurred With

Form 1769 (continued)

60. Is a JSA on File? [illegible] 61 Preventive Action [illegible]

[illegible]

Narrative/Complete Description of Accident

[illegible]

Hospital/Physician Information

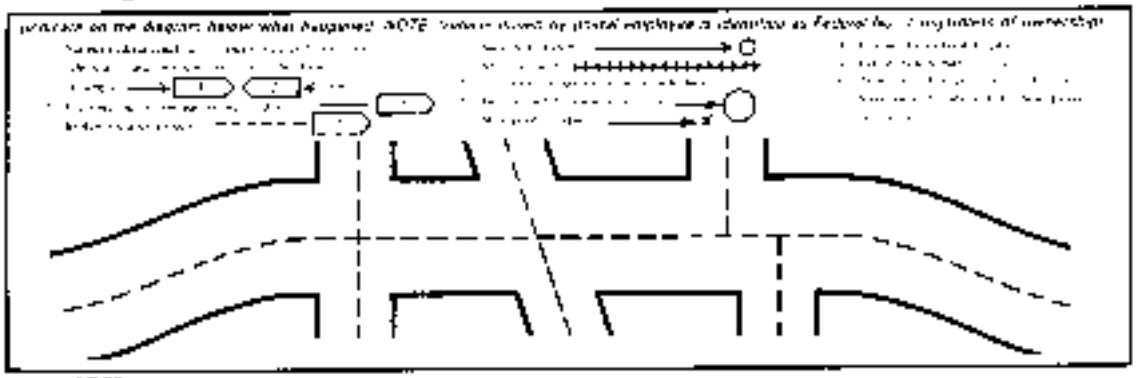
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

Hazardous Conditions and/or Equipment, Materials, Etc.

[illegible]

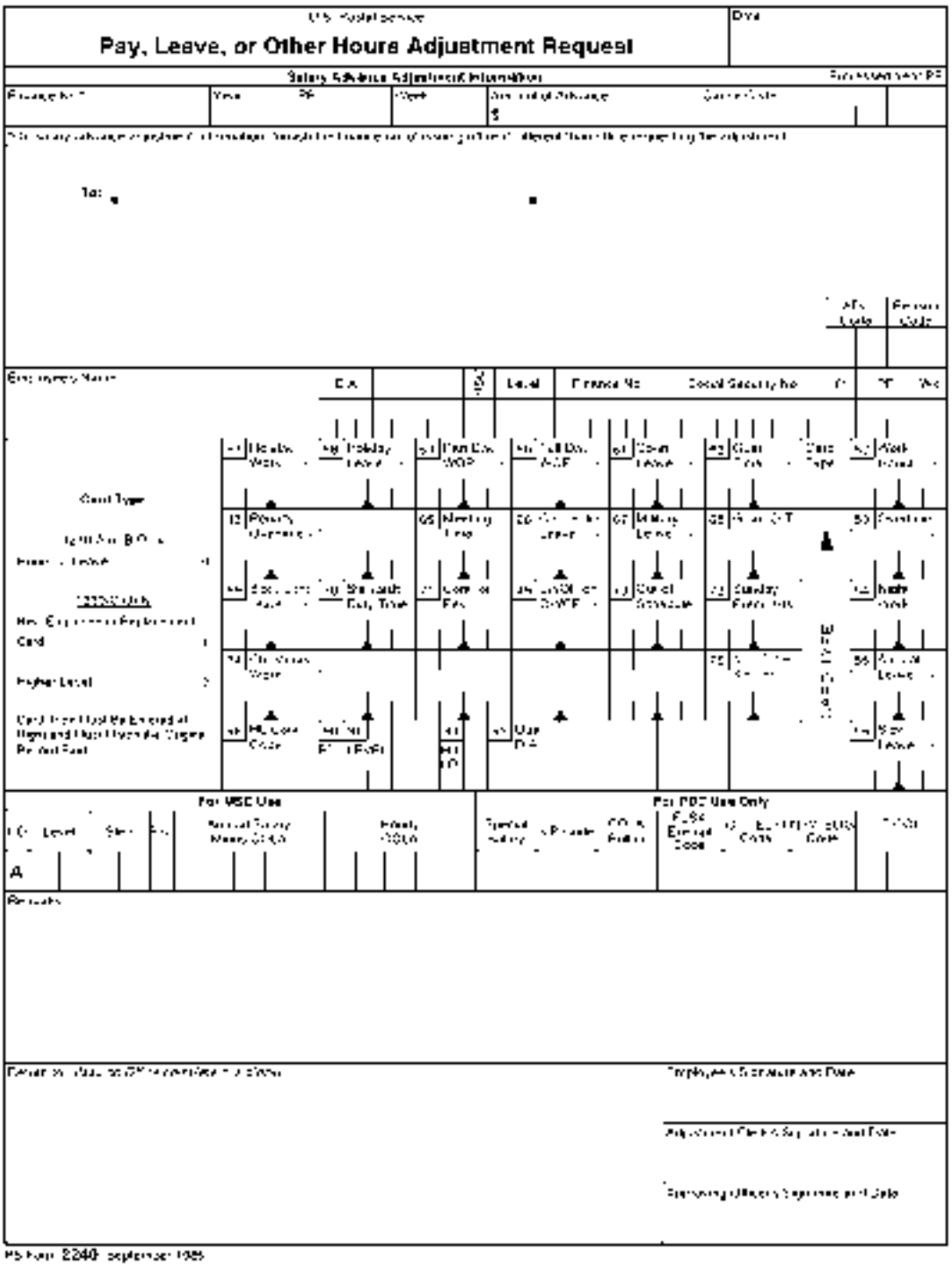
Vehicle Diagram *(For use of motor vehicle accidents)*

[illegible]



PS Form 1769, September 1991 (p. 2 of 2) [illegible]

Form 2240



Pay, Leave, or Other Hours Adjustment Request

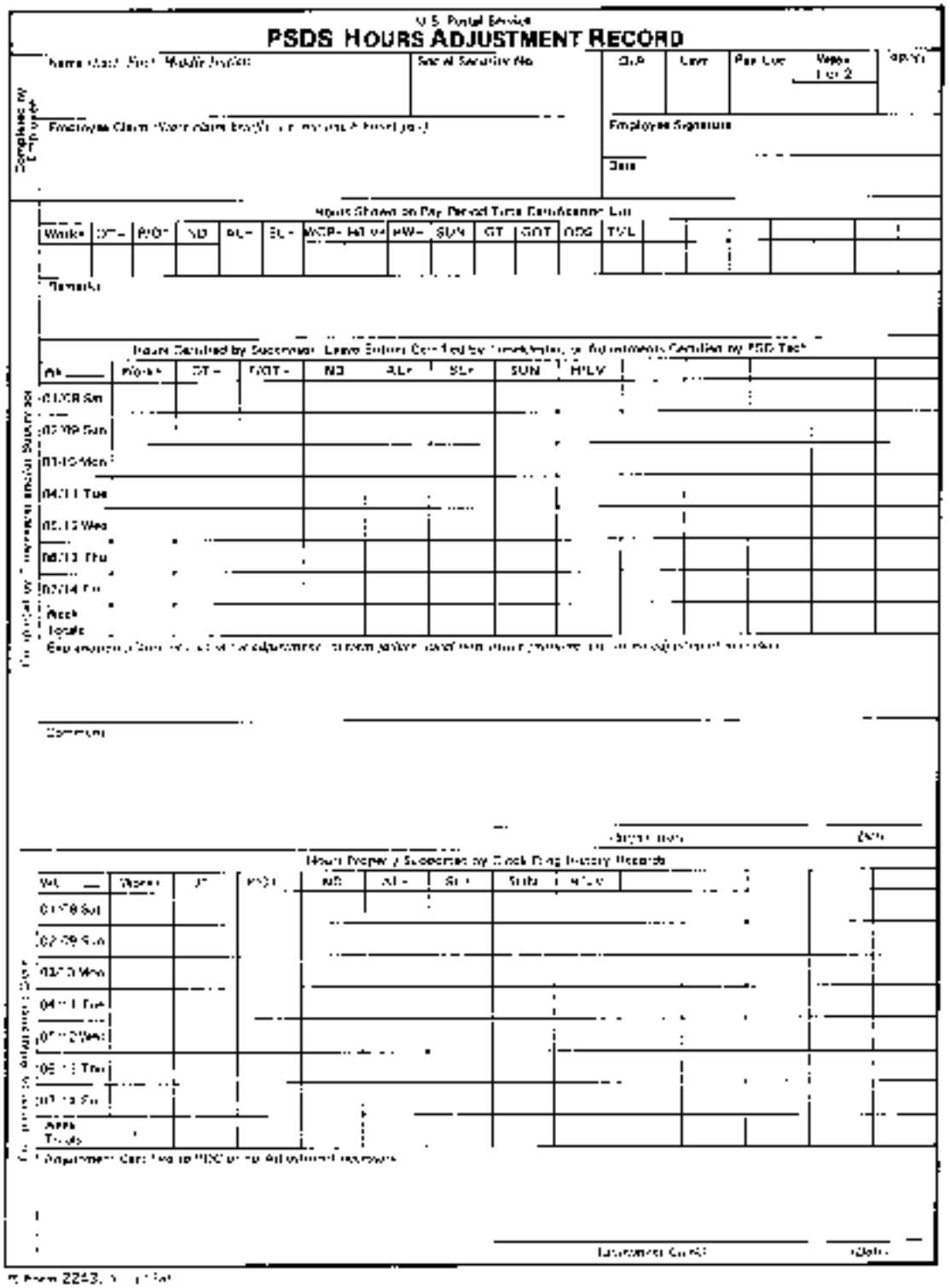
For USDC Use

For PDC Use Only

Remarks

PS Form 2240 September 1985

Form 2243



U.S. Postal Service

PSDS HOURS ADJUSTMENT RECORD

Name (Last, First, Middle Initial) | Social Security No. | CLK | Level | Pay Loc | Week 1 or 2 | (PP/Yr)

Employee Signature

Date

Hours Shown on Pay Period Time Conversion List

Week	OT	P/OT	ND	ALT	SL	WCP	HOL	HW	SUN	GT	GOT	ODG	TVL

Remarks:

Hours Certified by Supervisor Leave Errors Corrected by Timekeeper or Adjustments Certified by PSD Tech

Wk	Week	OT	P/OT	ND	ALT	SL	SUN	H'LV
01/08 Sat								
02/09 Sun								
03/10 Mon								
04/11 Tue								
05/12 Wed								
06/13 Thu								
07/14 Fri								
Week Totals								

Comments:

Hours Properly Supported by Clock Ring Timekeeping Records

Wk	Week	OT	P/OT	ND	ALT	SL	SUN	H'LV
01/08 Sat								
02/09 Sun								
03/10 Mon								
04/11 Tue								
05/12 Wed								
06/13 Thu								
07/14 Fri								
Week Totals								

Supervisor Certified

Date

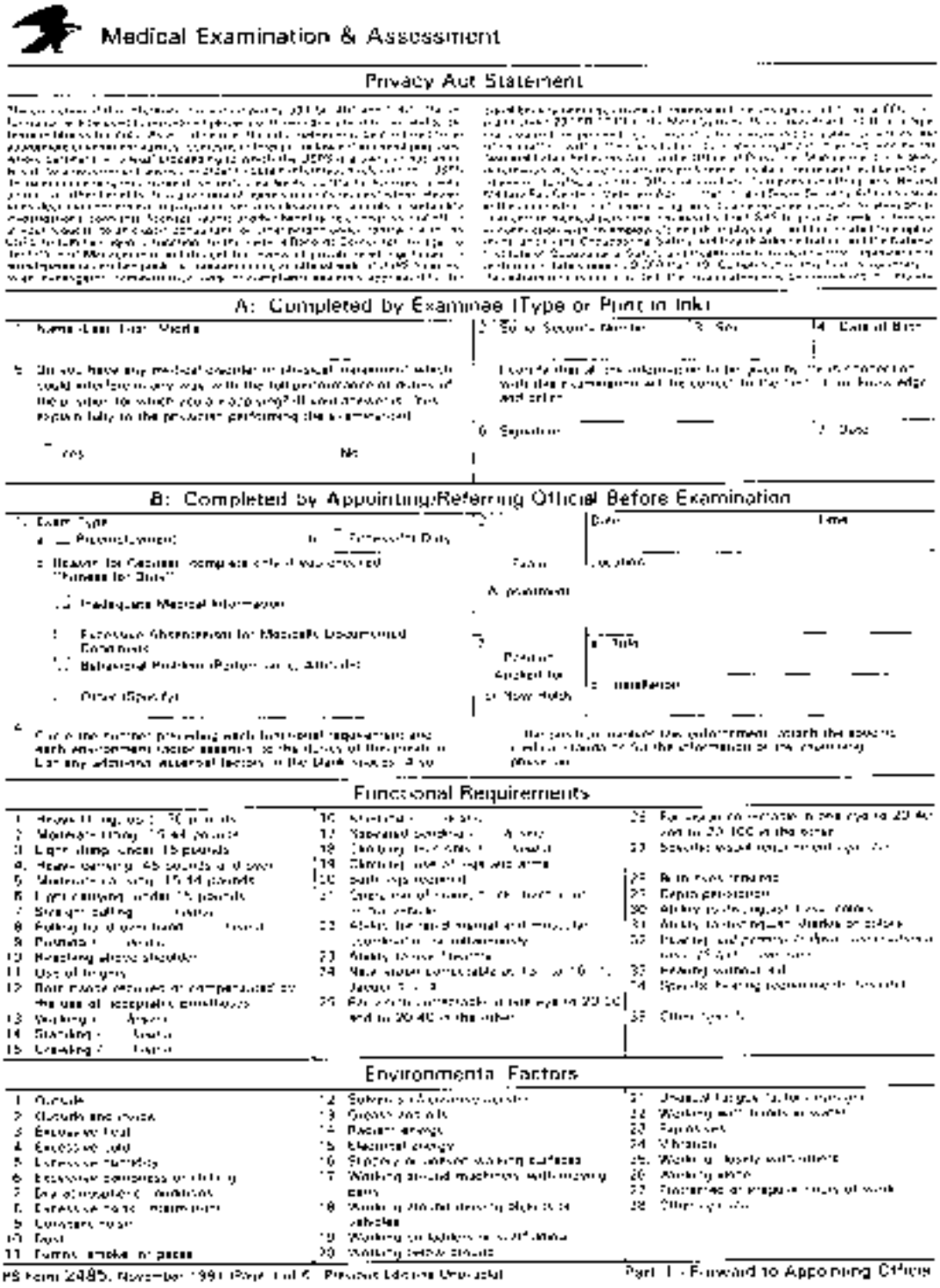
PS Form 2243, [illegible]

Form 2243 (continued)

The collection of this information is authorized by 39 USC 401, 1033, 1005, 5 USC 8149. It will be used to reflect accurate timekeeping. As a routine use, this information may be disclosed to a Federal agency when relevant to the administration of employment benefits and programs, including FECA, to an appropriate law enforcement agency for investigative or prosecution proceedings, to a congressional office at your request, to OMB for review of private relief legislation, to a labor organization as required by the NLRA, and where pertinent, in a legal proceeding to which the Postal Service is a party. Completion of this form is voluntary, however, if this information is not provided, you may not be paid for hours worked.

PS Form 2243, April 1989 (Reverse)

Form 2485



Medical Examination & Assessment

Privacy Act Statement

A: Completed by Examinee (Type or Print in Ink)

B: Completed by Appointing/Referring Official Before Examination

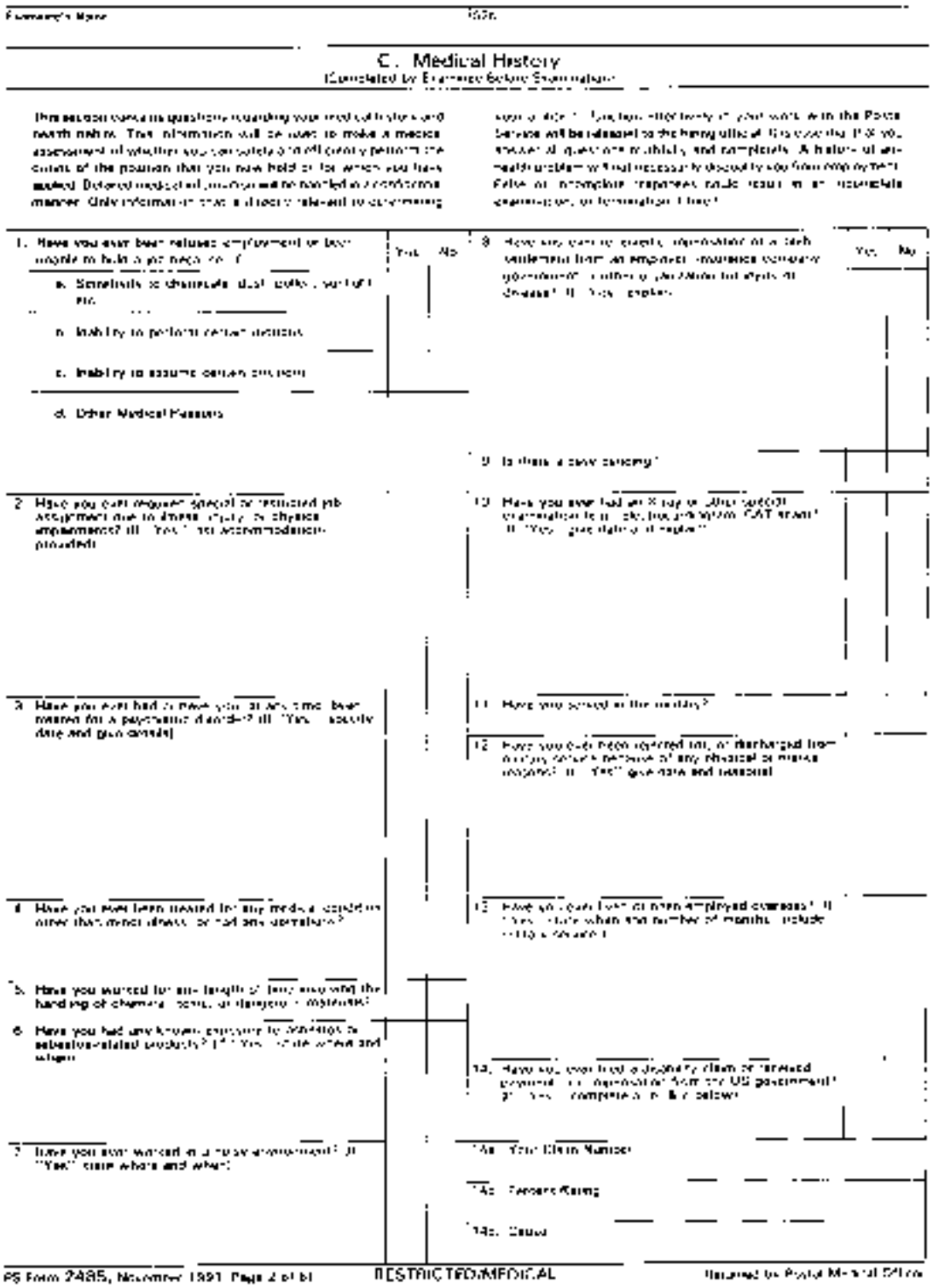
Functional Requirements

Environmental Factors

PS Form 2485, November 1991 (Page 1 of 4) Previous Editions Obsolete

Part I - Forward to Appointing Official

Form 2485 (continued)



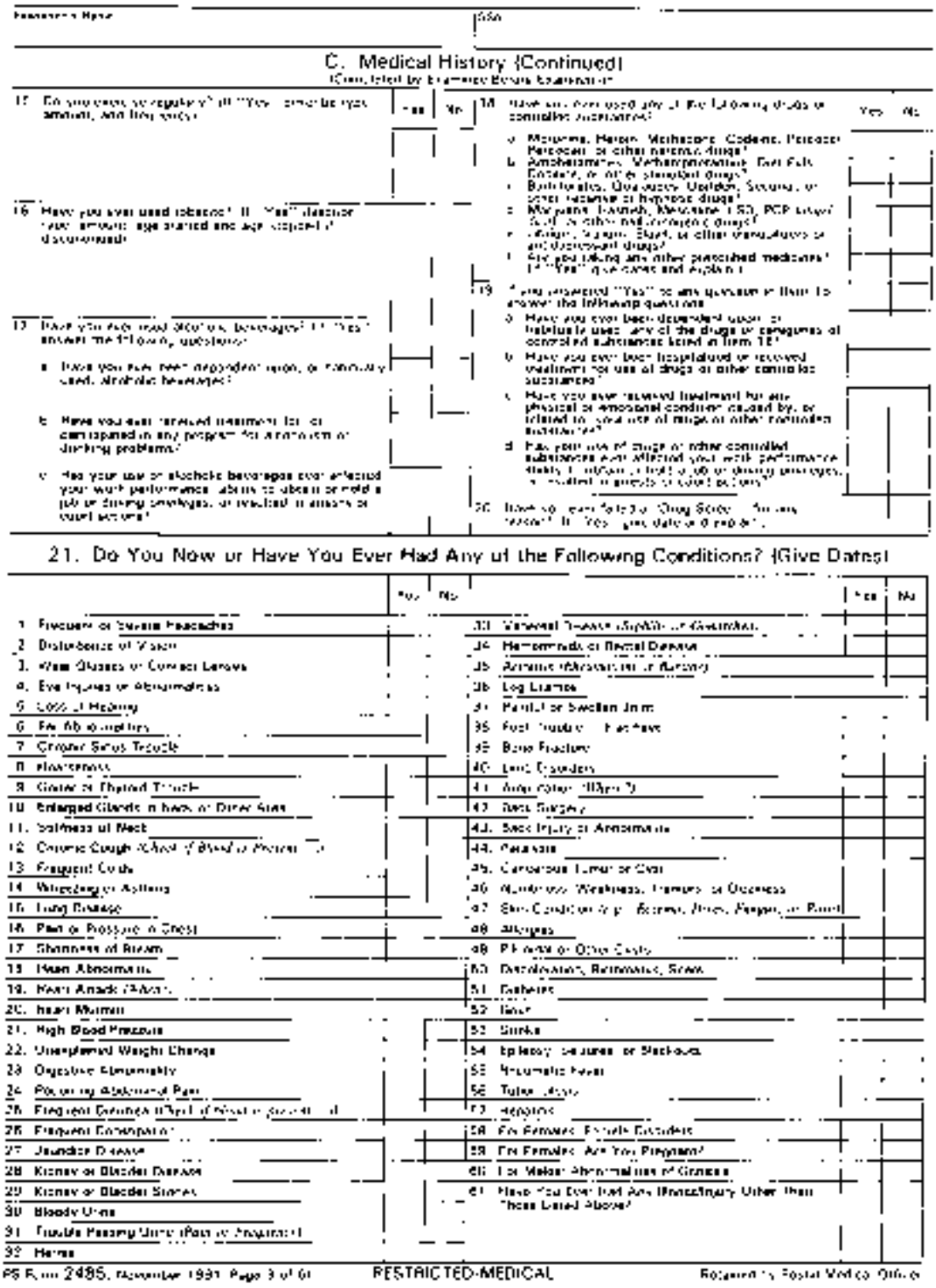
C. Medical History
(Completed by Examining Medical Officer)

This section contains questions regarding your medical history and health status. The information will be used to make a medical assessment of whether you can safely and effectively perform the duties of the position that you have held or for which you have applied. Determinations of employment are handled in a confidential manner. Only information that is directly relevant to determining your ability to safely and effectively perform your work in the Postal Service will be released to the hiring official. If you provide all questions are truthfully and completely. A history of ill-health problem will not necessarily disqualify you from employment. False or incomplete responses could result in an unfavorable examination, or termination if hired.

	Yes	No
1. Have you ever been refused employment or been unable to hold a job because of:		
a. Sensitivity to chemicals, dust, pollen, sunlight, etc.		
b. Inability to perform certain motions		
c. Inability to assume certain positions		
d. Other Medical Reasons		
2. Have you ever required special or restricted job assignment due to illness, injury, or physical impairments? (If "Yes," list accommodation provided)		
3. Have you ever had or have you at any time been treated for a psychiatric disorder? (If "Yes," specify date and give details)		
4. Have you ever been treated for any medical condition other than minor illness or had any operations?		
5. Have you worked for any length of time involving the handling of chemicals, solvents, or dangerous materials?		
6. Have you had any known exposure to asbestos or asbestos-related products? (If "Yes," state where and when)		
7. Have you ever worked in a nuclear environment? (If "Yes," state where and when)		
8. Have you ever received a disability claim or retired payment from an agency of the US government? (If "Yes," complete 8a & b below)		
8a. Your Claim Number		
8b. Percent Rating		
8c. Cause		
9. Is there a cane scoliosis?		
10. Have you ever had an X-ray or other special examination (i.e., electrocardiogram, CAT scan)? (If "Yes," give date(s) of exam)		
11. Have you served in the military?		
12. Have you ever been rejected for, or discharged from military service because of any physical or mental disability? (If "Yes," give date and reason)		
13. Have you been employed overseas? (If "Yes," state when and number of months. Include military service.)		

PS Form 2485, November 1991 Page 2 of 3 | RESTRICTED MEDICAL | Retained by Postal Medical Office

Form 2485 (continued)



C. Medical History (Continued)

21. Do You Now or Have You Ever Had Any of the Following Conditions? (Give Dates)

	Yes	No		Yes	No
1. Frequent or Severe Headaches			33. Venereal Disease (Syphilis or Gonorrhea)		
2. Disturbance of Vision			34. Hemorrhoids or Rectal Disease		
3. Wear Glasses or Contact Lenses			35. Anemia (Abnormal Blood)		
4. Eye Injuries or Abnormalities			36. Leg Cramps		
5. Loss of Hearing			37. Painful or Swollen Joints		
6. Ear Abnormalities			38. Foot Trouble		
7. Chronic Sinus Trouble			39. Bone Fracture		
8. Hoarseness			40. Lung Disorders		
9. Goiter or Thyroid Trouble			41. Asthma (Wheezing)		
10. Enlarged Glands in Neck or Other Area			42. Back Surgery		
11. Stiffness of Neck			43. Back Injury or Abnormality		
12. Chronic Cough (Cough of Blood or Phlegm)			44. Paralysis		
13. Frequent Colds			45. Cancerous Tumor or Cyst		
14. Wheezing or Asthma			46. Numbness, Weakness, Tremors or Dizziness		
15. Lung Disease			47. Skin Condition (e.g., Eczema, Hives, Allergy, or Rash)		
16. Pain or Pressure in Chest			48. Allergies		
17. Shortness of Breath			49. Pills, Herbs or Other Drugs		
18. Heart Abnormality			50. Discoloration, Removable, Sores		
19. Heart Attack (Angina)			51. Diabetes		
20. Heart Murmur			52. Ulcer		
21. High Blood Pressure			53. Stroke		
22. Unexplained Weight Change			54. Epilepsy, Seizures or Blackouts		
23. Digestive Abnormality			55. Rheumatic Fever		
24. Recurring Abdominal Pain			56. Tuberculosis		
25. Frequent Diarrhea (Type of Stool or Blood)			57. Hepatitis		
26. Frequent Constipation			58. For Females: Female Disorders		
27. Jaundice Disease			59. For Females: Are You Pregnant?		
28. Kidney or Bladder Disease			60. For Males: Abnormalities or Diseases		
29. Kidney or Bladder Stones			61. Have You Ever Had Any Illness(es) Other Than Those Listed Above?		
30. Bloody Urine					
31. Trouble Passing Urine (Pain or Frequency)					
32. Hernia					

PS Form 2485, November 1991 Page 3 of 6 RESTRICTED-MEDICAL Retained by Postal Medical Officer

Form 2485 (continued)

D. Medical Findings (For Preemployment and Fitness-for-Duty Exams)

(Completed by Examining Physician)

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine is being considered for a position for, if a Fitness-for-Duty exam, has a position which will include the functional requirements and environmental factors noted in Section B, Item 4. In conducting your examination and reporting your findings and conclusions, take these factors into consideration.

1. Examinee's Name | 2. SSN | 3. Height (in inches) | 4. Weight (Pounds)

5. Eyes

	Snellen (Distant Vision)	Jaeger (Near Vision)
Without Glasses	a. Right 20 ___ Left 20 ___	b. Right ___ at ___ in ___ Left ___ at ___ in ___
With Glasses	c. Right 20 ___ Left 20 ___	d. Right ___ at ___ in ___ Left ___ at ___ in ___

e. Is color vision normal? (Ishihara or other plate test is used) ☐ Yes ☐ No

f. If the answer is "No" can applicant pass Farnsworth or other color test? ☐ Yes ☐ No

6. Ears

a. Distance Conversation: Right ear @ 15 ft: ___ Left ear @ 15 ft: ___

b. Audiometer (Attach Audiogram if obtained)

7. Blood Pressure/Pulse

a. Systolic/Diastolic | b. Two Additional Readings (If Elevated) | Pulse

8. Urinalysis

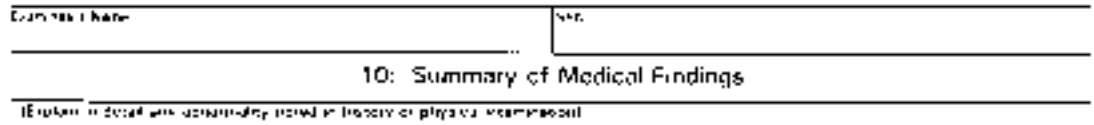
a. Albumin (Dipstick Test Only)	b. Sugar (Dipstick Test Only)	c. Blood (Dipstick Test Only)	d. Drugs (Limited to Tests Indicated)

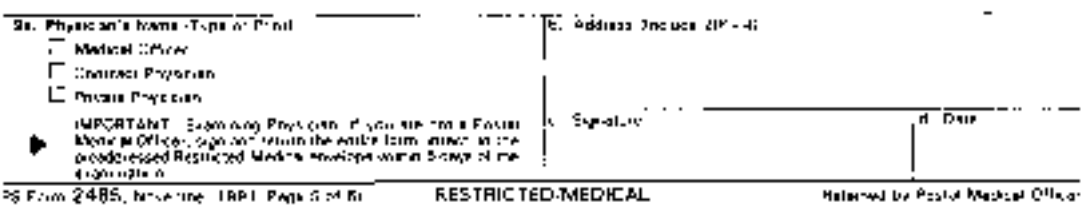
9. Physical Examination

NOTE: Routine pulse examinations are not part of a body motion study. Refer to an exercise physiologist.

Clinical Evaluation	Normal	Abnormal	Clinical Evaluation	Normal	Abnormal
a. Head, Face, neck and scalp			Anus and rectum (if indicated)		
b. Nose			m. Lymphatic system		
c. Mouth and throat			n. Hernia (Any type)		
d. Ears			o. Upper extremities		
e. Eyes			p. Feet		
f. Ophthalmoscopic			q. Lower extremities		
g. Ocular motility			r. Spine		
h. Lungs and Chest (Breathing)			s. Identifying body marks, scars		
i. Heart			t. Skin, lymphatics		
Cardiac Rate/BP (Two minutes after exercise)			u. Neurologic		
k. Abdomen			v. Mental status		

Form 2485 (continued)





Form 2485 (continued)

NOTE: Insert carbon from page 1 between parts 1 & 2 of this page before completing.

E. Medical Assessment by Postal Medical Officer/Contract Physician

Examinee's Name (Last, First, MI)	SSN

Complete All Items Below or Use Terms in Objective Review Considerations

1. **Medical History:** Based upon review of Section C of the Date Examinee's Medical History, VA records, if applicable, [illegible] medical records, and check appropriate box below. Note any significant past medical data that is pertinent to the physical and medical data that is relevant to the physical and mental requirements of the essential functions of the position applied for.

. No Significant Findings

! Significant Findings as Noted. (Observe privacy considerations)

2. **Physical Findings:** Based upon a complete physical examination and mental status examination if indicated. Check appropriate box below.

" No Limitations/Restrictions

. Limitations/Restrictions as noted

' Specialist Exam Required with Narrative Report
Note any restrictions on mobility and/or limitations (sitting, standing, climbing, etc.)

Do not complete item 4 below until specialist's report is received.

3. **Employment History:** Based on review of examinee's SF Form 255, application for Employment or supervisor's evaluation, or job description, etc., check appropriate box below. Note any employment data that is pertinent to past or current medical conditions. Note only that employment data which supports the examinee's ability to perform the essential functions of the position to which the examinee has applied.

[No Significant Findings

] Significant Findings as Noted

4. **Risk Assessment** NOTE: Do not complete this section until applicable medical report(s) required has been received.

Based upon a review of findings as noted in Nos. 1, 2, above, my risk assessment of applicant's risk of sustaining [illegible] injury or illness within [illegible] months due to applicant's pre-existing medical conditions:

[ ] No Medical Risk Restriction. Examinee is medically qualified to perform essential functions of the position with no accommodations noted.

[ ] Moderate Risk Restriction. Examinee would be medically qualified to perform essential function of the position only if below noted accommodations can be accomplished. (See No. 5 below.)

[ ] Low Risk Restriction. Examinee is medically qualified to perform essential functions of the position at this time. Examinee has periodic medical follow-up is recommended. (See No. 5, below.)

[ ] High Risk Restriction. Examinee is not medically qualified to perform essential functions of the position. Accommodations would not reduce medical risk to acceptable level.

5. **Suggested Accommodations:** Job modifications which would allow examinee to perform essential functions of the position effectively and safely:

Signature of Medical Authority	Date	Name and Location (Type or Print)

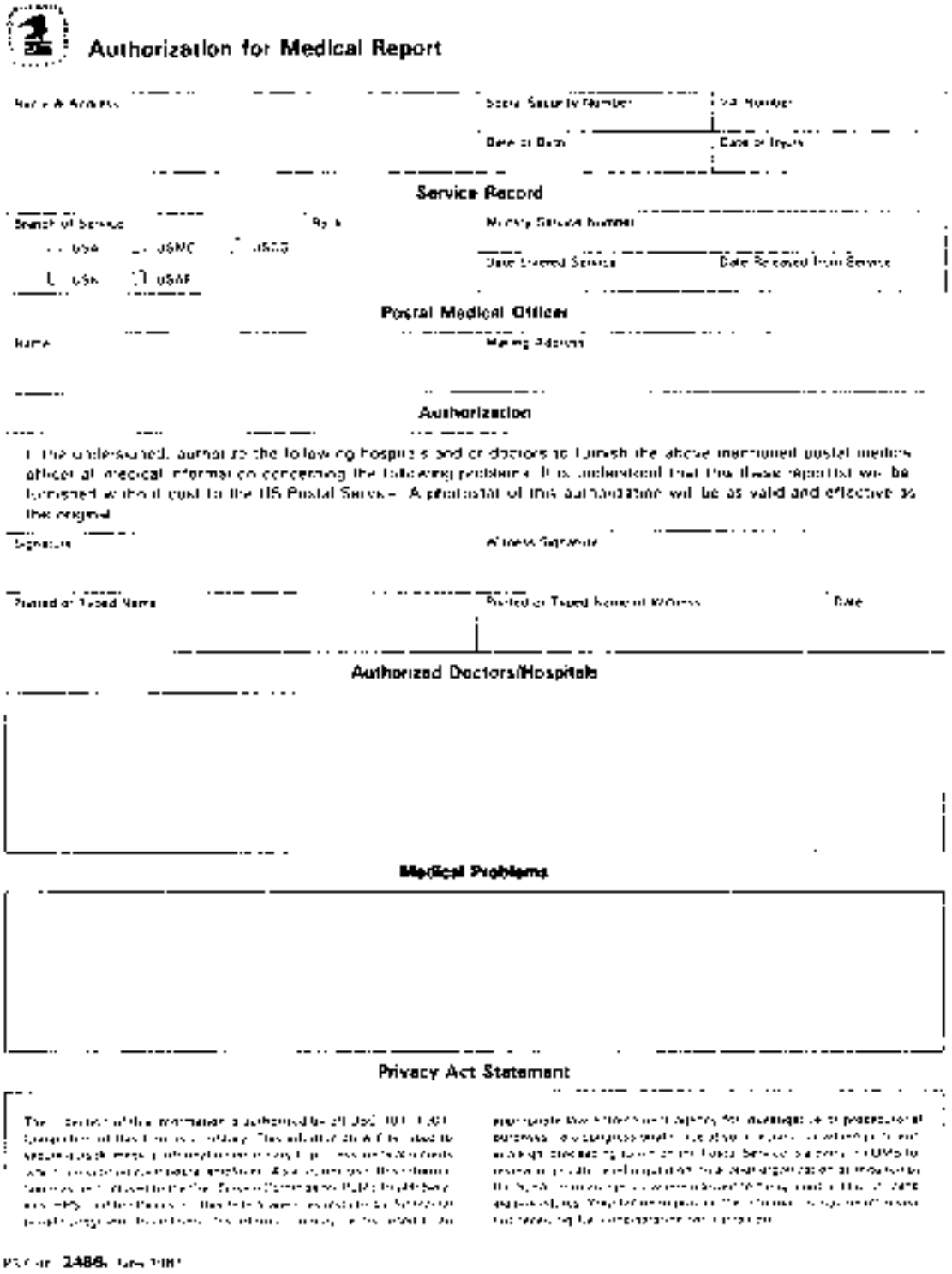
F. Completed by Appointing/Referring Official (HBK-EL 311.343.5)

Final Action Taken	Name & Location (Type or Print)

[ ] Selected for Appointment [ ] Fit for Duty

[ ] Not Selected for Appointment [ ] Not Fit for Duty | Signature | Date

Form 2488



Authorization for Medical Report

Name & Address

Social Security Number | VA Number

Date of Birth | Date of Injury

Service Record

Branch of Service | Rank

USA | USMC | USCG

USN | USAF

Military Service Number

Date Entered Service | Date Released from Service

Postal Medical Officer

Name

Mailing Address

Authorization

I the undersigned, authorize the following hospitals and doctors to furnish the above mentioned postal medical officer all medical information concerning the following problems. It is understood that this release report will be furnished without cost to the US Postal Service. A photostat of this authorization will be as valid and effective as the original.

Signature

Witness Signature

Printed or Typed Name

Printed or Typed Name of Witness

Date

Authorized Doctors/Hospitals

Medical Problems

Privacy Act Statement

The [illegible] of the information is authorized by 39 USC 401, 1001 [illegible] of Workers' Compensation Claims. The information on this form is used to [illegible] appropriate medical personnel in the processing [illegible] Failure to furnish the information may [illegible] appropriate Department of Labor, Office of Workers' Compensation Programs, Publication [illegible] Routine Uses [illegible] may be disclosed to [illegible] appropriate Federal, State, local or foreign agency for [illegible] civil or criminal [illegible] or pursuant to the [illegible] Postal Service systems [illegible] to provide information [illegible] organization or individual [illegible] the Postal Service [illegible] employee [illegible] Privacy Act [illegible] compensation [illegible]

PS Form **2488**, June 1981

Form 2489

Identification of Physical/Mental Disability

See Privacy Statement on Reverse

The examining physician completes this form and forwards it to the appointing official along with PS Form 3485, Medical Examination and Assessment. The form is RESTRICTED. Do not put the form into the Official Personnel Folder. After the disability code is entered on PS Form 50, return the form to the Postal Medical Officer (or retain it along with Form 3485).

A reasonable disability is a physical or mental impairment that substantially limits one or more major life activities (e.g., caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working) or a record of such an impairment. In cases of multiple disabilities, choose the code for the one that is most disabling.

Name (Last, First, MI)	Social Security Number	Date
Date Started	Prior Applicable Code Date	

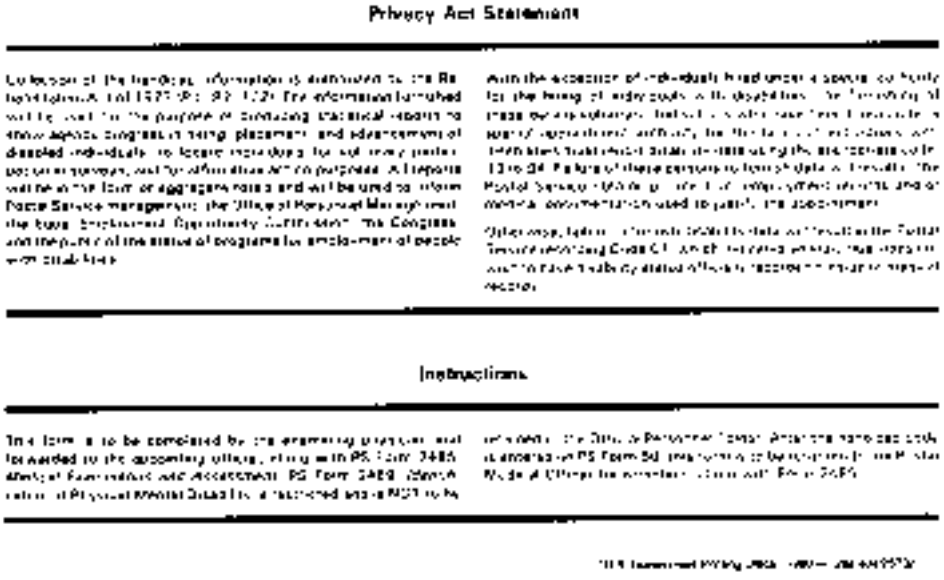
Disability Codes

Code	Illness
01	Disability Not Reported
05	No Disability
06	Disability Not Listed on This Form
Speech Impairments	
12	Severe speech malfunction or inability to speak hearing impaired. Examples: defects of articulation (prolonged pronounced stuttering, palatolalia, amygdalectomy, removal of the vocal box)
Hearing Impairments	
15	Hard of hearing (correctable by hearing aid)
18	Total deafness with understandable speech
11	Total deafness with inability to speak clearly
Vision Impairments	
22	Can read ordinary size print with glasses, but with loss of peripheral field vision
23	Cannot read ordinary size print, not correctable by glasses
24	Blind in one eye
28	Blind in both eyes
Missing Extremities	
31	One hand
32	One arm
33	One foot
34	One leg
35	Both hands or arms
36	Both feet or legs
37	One hand or arm and both feet or legs
38	One hand or arm and one foot or leg
39	Both hands or arms and both feet or legs
Musculoskeletal, Orthopedic Impairments (Because of chronic pain and/or loss or weakness in bones or joints. There is some loss of ability to move or use a part of the body.)	
64	One or both hands
65	One or both feet
66	One or both arms
67	One or both legs
68	Hip or pelvis
69	Back
67	Any combination of two or more parts of the body
Partial Paralysis (Because of a brain injury, stroke, multiple sclerosis, muscular dystrophy, cerebral palsy, there is some loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)	
51	One hand
52	One arm, any part
53	One leg, any part

Code	Partial Paralysis (Continued)
54	Both hands
55	Both legs, any part
56	Both arms, any part
57	One side of body, including one arm and one leg
58	Three or more major parts of the body (arms and legs)
Complete Paralysis (Because of a brain injury, stroke, multiple sclerosis, muscular dystrophy, cerebral palsy, there is complete loss of ability to move or use a part of the body, including legs, arms, and/or trunk.)	
29	One hand
31	Both hands
32	One arm
33	Both arms
34	One leg
35	Both legs
36	Upper half of body, including both arms and legs
37	One side of body, including one arm and one leg
38	Three or more major parts of the body (arms and legs)
Other Impairments	
80	Heart disease with any restriction or limitation of activity (History of heart problem with complete recovery.)
81	Heart disease with restriction or limitation of activity
82	Convulsive disorder (e.g., epilepsy)
83	Mental disorder (e.g., schizophrenia, manic depression, neurosis)
84	Diabetes
85	Pulmonary or respiratory (e.g., tuberculosis, emphysema, asthma)
87	Allergy, deficiency/allergy (e.g., loss of an antibody, allergic reaction)
88	Cancer (a history of cancer with complete recovery)
89	Cancer (undergoing therapy, or positive history for cancer)
92	Severe limitation of limbs and/or spine (e.g., deviation, deformity, severe distortion of back, etc.)
91	Disfigurement of face, hands or feet (e.g., distortion of features or skin, such as those caused by burns, gunshot wounds, and birth defects, great facial disfigurement, club feet, etc.)
Work Restriction/Employment Problems	
50	A chronic and lifelong condition involving a mental ability to learn to be educated and to be trained for useful participation in employment as defined by a State Vocational Rehabilitation Agency
51	Mental or nervous disorder in need of treatment by mental or emotional problems
98	Learning Disability

PS Form **2489**, April 1988

Form 2489 (continued)



Privacy Act Statement

Collection of the information is authorized by the Rehabilitation Act of 1973 (P.L. 93-112). The information furnished will be used for the purpose of collecting statistical reports to show aspects concerned with placement and advancement of disabled individuals to locate responsible for administering particular personnel surveys, and for administrative purposes. All reports will be in the form of aggregate data and will be used to inform Postal Service management, the Office of Personnel Management, the Equal Employment Opportunity Commission, the Congress and the public of the status of programs for employment of people with disabilities.

With the exception of individuals employed under a special authority for the hiring of people with disabilities, the [illegible] of these employees [illegible] under the [illegible] of the Privacy Act of 1974 [illegible] Postal Service [illegible] of employee records and [illegible] information used to [illegible] the assessment.

Otherwise, [illegible] data [illegible] Federal Equal Employment Opportunity Commission [illegible] and to [illegible] by duly authorized officials [illegible] of records.

Instructions

This form is to be completed by the supervisor [illegible] and forwarded to the appointing official, along with PS Form 2488, Medical Examination and Assessment. PS Form 2489 (Statement of Physical Mental Disability) is returned and is NOT to be [illegible]

PS Form **2489**, April 1988 (Reverse)

Form 2491

UNITED STATES POSTAL SERVICE

Medical Report - First Aid Injuries

Part A - Supervisor

1 Name and Address of Employee Physician Contacted for Follow-Up Medical Care	2 Check the Appropriate Block [ ] Initial visit to physician [ ] Treated at Postal facility [ ] Treated at home [ ] Hospitalized [ ] Subsequent visit [ ] Treated at Postal facility [ ] Treated at home [ ] Hospitalized
3 Employee's Name	4 Employee Occupation

5 Employee's SSN	6 Date and Time of Injury (Hr. Day, Mo., Yr.)	7 Witness to Injury? [ ] Yes [ ] No

8 Brief Description of Injury

Part B - Physician Please Note: See Notice on Reverse

9 Diagnosis	10 Prognosis

10A Is Employee Capable of Performing Regular Duty?

[ ] Yes [ ] No

10B If Yes, and the employee is a member of a craft that requires a license, has the employee's license been renewed and is it current? If No, explain.

10C Is Employee Capable of Performing Limited Duty? If Yes, complete Form 2956 and attach. If No, explain.

[ ] Yes [ ] No

11 Physician Name (Please Print)

12 Date

NOTE TO EMPLOYEE: Your immediate supervisor will complete Form 2 and forward it to the office listed in Item 1 of Part A.

PS Form 2491 June 1986

1 - Injury Compensation
2 - Physician Records
3 - Employee

Form 2491 (continued)

Notice to Contract Physicians

The employee has sustained an on-the-job injury and is referred to you for treatment. The Federal Statute will reimburse you for the cost of the initial visit and any additional visit if needed, for review of the records. Any visits for further treatment is only if treatment is required beyond the second visit and the employee elects to continue treatment with you. You will receive payment directly from the Federal Office of Workers' Compensation Programs (OWCP) not the employee.

The OWCP has implemented a fee schedule of maximum allowable medical charges for services. Medical bills for services provided after January 1, 1986 which exceed the maximum allowable will be reduced by OWCP in accordance with the fee schedule. A medical provider whose charge for service is only partially paid because it exceeds the maximum allowable may not seek more than OWCP's fee schedule may within 30 days of payment request reconsideration of the fee determination to the OWCP. Request for reconsideration procedures are outlined in OWCP's medical fee letter to the medical provider.

CA-Form 2491 July 1988 (Reverse)

Form 2556

U.S. Postal Service
Third Party Statement of Recovery ▶ *See Instructions on Reverse*

Form No.

Claimant	Date of Injury/Death	NSC	Payment No.
1 Gross Recovery			$
2 Less Property Damage			
3 Balance			
4 Less Attorney's Fee of ____ % of line 3			
5 Balance			
6 Less Court Costs (Must be itemized)			
7 Balance (Subtotal Gross Recovery)			
8 Less 1/5 (20%) of line 7			
9 Balance			
10 Less Payment to Public Health Service or other Federal medical facility			
11 Balance			
12 Less Medical Expenses Paid by the Claimant (Must be itemized)			
13 Balance			
14 OWCP Disbursement (Compensation and interest on line 13 or the lesser of)			
15 Less Government Attorney or Collection Fee Retained by Claimant			
16 Amount to Be Returned to OWCP (Enclose check or money order payable to OWCP)			
17 Supplemental (Lesser of line 14)			$
For Official Use Only			

PS Form 2556 (xx, 1995)

Form 2556 (continued)

Instructions

•Disbursement must be made in accordance with A.R.S. 23-1... Also provide the employee with a copy of this form.
NOTE: Do not use for "Partial Use Only."

Property Damage, (line 2): A reasonable amount for clothing or other personal belongings damaged or destroyed in an accident may be included. These amounts must be itemized. If applicable, the vehicle's damage or cost should not exceed the value of such damaged or injured. The year, make, model and Blue Book value of the vehicle must be furnished. A copy of the repair bill will suffice if the vehicle was not totally destroyed.

Attorney's Fee, (line 4): Deduct the claimant's fee in accordance from the balance shown on line 3. The attorney's fee as a percentage or fixed amount may also be shown.

Court Costs, (line 5): These consist of such items as filing fees, witness fees, court reporting costs, or any payments to physicians for expert testimony as opposed to payment for treatment. •Payment for medical testimony comes under line 12, Section 12. All costs must be itemized.

20% Guarantee, (line 6): This amount is deducted from the claimant's check and is not subject to any deductions.

Public Health Service, (line 10): Refund made to U.S. Veterans Medical Facility for medical treatment rendered under Title 10. The claim of the Federal Medical Facility or personnel for payment from the claimant is the OWCP.

Medical Expense Paid By Claimant, (line 12): This consists of any medical expenses paid by the claimant that have not been paid by OWCP or by any insurance carrier. Bills or receipts for payment by the claimant for which the claimant was subsequently reimbursed by the OWCP or by any insurance carrier must be attached. Amounts deducted on line 12 or which appear on your bill. A copy of each invoice will not be accepted for credit.

Government Allowance for Attorney's Fee, (line 15): The Government contributes a portion of its refund to the claimant's attorney fee. This fee is based upon the OWCP's recovery or other amount as shown on line 4.

Amount to Be Refunded, (line 16): This represents the amount to be refunded to the Second Injury Fund for OWCP disbursements. Refund check must be made payable to the OWCP.

Surplus, (line 17): This surplus which is returned by the claimant is the amount against which the OWCP will not make future consideration or payments for additional medical expenses payable on account of the same injury or death.

Form 2557

Employee's Third-Party Recovery Statement

Page No.

Claimant	Date of Injury/Death	OWCP	Claim No.

When a Third-Party Settlement Is Made Without an Attorney

1. Complete this statement and return it to the office that sent it to you.

2. If you were examined or treated at a Federal medical facility, contact the facility to request a statement of the value of the services. If services were provided by the U.S. Public Health Service or the Federal Bureau of Prisons, the Department of Health and Human Services should be contacted.

3. Complete the recovery statement below and return it to this office. Please enclose a check or money order for the amount requested in item 4 below. Make payable to "Office of Workers' Compensation Programs (OWCP)."

The law provides that the United States must be reimbursed out of any third-party recovery for any compensation or medical benefits paid by the Government. The term "third-party" includes compensation or medical benefits paid under any law of the United States, a State or a foreign country. If you were also awarded damages relating to pain and suffering, you are entitled to a reasonable amount of the recovery attributable to any items the Government does not pay for (see item 2 above).

1. Total recovery		$ _____
2. Less:		
a. Personal property damage		$
b. Balance due Third-Party Carrier		$ _____
c. Minimum guarantee (25 percent of item 1) to be retained by you		$
d. Medical expenses paid by you for which you have not received reimbursement from OWCP or another source (attach explanation)		$
e. Adjusted balance (item 2b less items 2c and d)		$ _____
3. OWCP compensation and medical benefits paid	$ _____	$ _____
4. Surplus (overpayment)		$

Following submission of this statement, you will be advised further concerning your compensation status.

Date of Judgment or Release	Signature	Date

The Federal Employees Compensation Act (5 U.S.C. 8101 et seq.) and regulations (20 CFR 10.700 et seq.) authorize the Office of Workers' Compensation Programs of the U.S. Department of Labor, in connection with its responsibilities, to collect and maintain personal information on claimants and their immediate families. This information will be used to determine eligibility for and the amount of benefits payable under the Act. The Postal Service uses the information in handling matters relating directly or indirectly to the employment of the claimant in accordance with the provisions of 39 U.S.C. 401. In addition, this information may be disclosed to the appropriate law enforcement agency for investigative purposes; to a congressional office at your request; to OMB for review of private relief legislation; to a labor organization as required by the NLRA; and when a pertinent civil legal proceeding is in which the Postal Service is a party. Failure to furnish the information requested may delay the adjudication process or result in an unfavorable decision or a reduction in benefits. However, disclosure of the social security number is voluntary and will not cause such delays. It may be necessary for the Postal Service to exchange this information with other agencies to verify the status and amount of benefits due the Department of Labor.

PS Form 2557, Jul. 1990 — Copy to Employee

Form 2559

UNITED STATES POSTAL SERVICE

Third Party Claim - Information Request

Section 8132 of Title 5, United States Code, provides that when damages are recovered the United States shall be reimbursed for payments made or expenses incurred in the case.

1. Have you presented a claim or brought suit for damages against any person or persons arising out of the injury? ☐ Yes ☐ No
If "Yes," give the name and address of the person against whom claim was presented or suit brought.

Third Party Name and Address	Insurance Carrier Name and Address

2. Have you retained an attorney with regard to possible action against any person or persons responsible for your injury? ☐ Yes ☐ No
If "Yes," give the attorney's name and address.

3. If you have settled a claim or brought suit, give details, including date, amount, and terms.

4. Has damage been repaired? ☐ Yes ☐ No (If "Yes," please complete the following information.)

a. Total amount of repair bill ..... $

b. Personal property damaged (If any) ..... $

c. Medical expenses paid by you personally (Do not include those billed or reimbursed by OWCP or a medical insurance carrier.) (If any) ..... $

d. Attorney's fee (If any) $

Date Claim Received by Postal Service	Signature	Date

The Federal Employees' Compensation Act, as amended (5 USC 8101 et seq.), is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with the Act, we will ask you for information concerning personal injuries or claims and recoverable benefits. The information will be used to determine eligibility for and the amount of benefits payable under the Act. The Postal Service uses this information to identify, allocate liability for, or recover costs from the proper party in the disposition of the claim in accordance with the provisions of 20 CFR 10.700. In addition, the information may be disclosed to the appropriate Federal, state, local, or foreign agency for law enforcement purposes; to a congressional office at your request; to OMB for review of private relief legislation; to another agency or its contractor engaged to assist in the performance of a Federal function; to an agency or organization for the purpose of investigating individuals who have a financial interest in your compensation in connection with program integrity initiatives; to a grand jury, agency or court when the Federal Government is a party to the judicial or administrative proceeding. In those cases where the Federal Government is not a party to the proceeding, records may be disclosed if a subpoena has been signed by a judge. Failure to furnish the requested information may delay your claim or result in denial of your claim. Furnishing the social security number (SSN) is voluntary, but it will assist in properly identifying records and will be used for no other purpose. The Postal Service may use your SSN to request additional information from you or your physician during the period of your claim. Please see the privacy act statement in reference 10 for additional information.

PS Form 2559, February 1987

Form 2560

UNITED STATES POSTAL SERVICE

Referral of Third Party Material

Attached Are the Following Documents:

1. CA Forms (Check)

- ☐ CA-1
- ☐ CA-2
- ☐ CA-3
- ☐ CA-5
- ☐ CA-7
- ☐ Other (Identify)

2. Attorney, guardian, or Assigned Papers

- ☐ Request (CA-1 or CA-2)
- ☐ Other (Identify)

3. Medical Report

- ☐ CA-16 (Request)
- ☐ CA-20
- ☐ CA-20a
- ☐ Other (Identify)

4. Claim-related Forms

- ☐ Attorney Dated
- ☐ Claimant Dated
- ☐ Other (Identify)

5. Award of Compensation

- ☐ CA-108
- ☐ CA-1031
- ☐ CA-1501
- ☐ CA-1501
- ☐ Other (Identify)

6. Settlement

- ☐ Claimant's Receipt by Statement
- ☐ Settlement Not Been Made on This Case (Attach Copy, if
- ☐ Payment Made

PS Form 2560 (December 1995)

Form 2562

UNITED STATES POSTAL SERVICE

**Injury Compensation Program -
Notice of Potential Third Party Claim**

1 Date

A. Employee Information

1 Name	3 Home Address (Include Zip4) Number & ZIP Code
2 Social Security Number	
5 Title	6 Work Phone (Include Area Code)
7 Office of Employment	8 Contact Postal Employing Office Name & Phone Number

B. Injury Information

1 Date & Location of Injury	2 OWCP File Number

3 Brief Description of Injury

4 Name & Address of Treating Physician (Include Zip4)

5 Name & Address of Hospital Treating Employee (Include Zip4)

6 Have Police, Medical Records, and Other Relevant Information (e.g., Eyewitnesses) Been Secured?

☐ Yes ☐ No

C. Third Party Information

1 Name	2 Address (Include Zip4) Number & ZIP Code

3 Does the Employee Intend to Pursue Action Against the Third Party? (If Yes, Contact the Solicitor)

☐ Yes ☐ No

4 Name & Address of Individual & Firm Representing Employee (Include Zip4)	5 Name & Address of Law Enforcement Agency (If Any)
Prepared By (Printed Name & Signature)	Date Signed

PS Form 2562, December 1995

Form 2562 (continued)

- Completion of Form 2562 by third party is dependent on receipt of completed Form 2561 from employee has applied for compensation benefits.
- A third party may be involved directly or indirectly such as designing or manufacturing an unsafe piece of machinery or equipment.
- The employee or employee's beneficiaries are encouraged to seek recovery from a third party that they believe is responsible for the employee's work-related injury. An employee or employee's beneficiaries who accept payment from a third party without taking action against the third party may become ineligible for injury compensation.

The Federal Employees Compensation Act, as implemented by OWCP regulations at 20 CFR 10, is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with the responsibility to inform claimants and others of the information and the immediate liabilities. The information will be used to determine eligibility for and the amount of benefits payable under the Act. The information may be used by employees who have filed claims for benefits under the Act or by persons who are authorized to receive such information. Failure to furnish the information may delay a decision or may result in denial of benefits. While you are not required to respond, you may not receive benefits if you do not provide all requested information. The information may be disclosed to another federal agency for the purpose of determining eligibility for similar benefits, for statistical studies, in connection with litigation, or by routine uses published in the Federal Register. If you are a party to a litigation, you may obtain information by filing a request under the Freedom of Information Act. Failure to provide the information requested may delay the adjudication process. In addition, it is possible that failure to furnish the requested information could result in a determination that you have forfeited your right to compensation. Disclosure of your social security number is mandatory. It will be used to identify your case file and to process your claim. Failure to disclose your social security number may result in a determination that you have forfeited your right to compensation.

Form 2562 December 1995

Form 2573

U.S. Postal Service

REQUEST - OWCP CLAIM STATUS

OWCP File No.

Section A

To:

OFFICE OF WORKERS COMPENSATION PROGRAMS
UNITED STATES DEPARTMENT OF LABOR

Instructions

a. Requester. Enter the information requested in Section A. Check the appropriate box in Section B and forward to the appropriate OWCP District Office for action.

b. OWCP Office. We received a claim for compensation from the employee named in Section A. Please help us determine the claimant's status by completing Section B and returning this form to the requester.

Requester

Name

Address

Date

Claimant

Name

Work Address

Date Signed

Section B

This is related to the claim for injury, or illness, dated

1. ☐ Claim Is Accepted

☐ a. Accepted Date

☐ b. Received Date

☐ c. Pending

2. ☐ Employee Is Currently Receiving Compensation

☐ Yes (Complete item 3)

☐ No

3. ☐ Type And Amount Of Payment

☐ a. Temporary Total Disability of
$ _____ Per _____

☐ b. Permanent Total Disability of
$ _____ Per _____

☐ c. Loss Of Wage Earning Capacity Of
$ _____ Per _____

☐ d. Scheduled Award Of
$ _____ Per _____
Terminates On _____

4. ☐ Last Medical Examination Dated

Attending Doctor

5. ☐ Other (Specify)

Signature And Title Of OWCP Official

Date

Form 2577

UNITED STATES POSTAL SERVICE

Assignment of Claim to the USPS

As a result of my applying for and receiving benefits under the provisions of the Federal Employees' Compensation Act (5 U.S.C. 8101-52) and because I do not wish to prosecute an action in the courts for damages, I (Name) _____ of (Address) _____ City or _____ County or _____ State of _____ hereby voluntarily assign to the United States Postal Service all my right, title and interest in any claim, demand or cause of action which I may have against (name of third party) _____ _____ or any other person as a result of an injury I sustained on (Date) _____ (Location) _____ while in the performance of my duties as an employee of the United States Postal Service.

I understand that the value of recovery of damages to the United States Postal Service under this assignment is limited to the net amount of recovery after expenses thereof have been deducted and to any right to reimbursement as provided by Section 8132 of the Federal Employees' Compensation Act.

I understand that I have the right to prosecute my action to recover damages by myself or by an attorney of my own choice but I hereby irrevocably assign my right to the United States Postal Service. Upon receipt of this assignment, the United States Postal Service will have full power to prosecute or settle my claim in my name or in the name of the United States Postal Service and to execute releases and to do all other things necessary to the prosecution, settlement or compromise of the claim or any suit or execution thereon. I shall have the right to cancel this assignment and thereby reassign the claim back to me.

I hereby authorize the United States Postal Service to furnish all records, medical and other reports, statements made by myself or other persons, etc., to any agent of the parties against whom a claim is made, their representatives and insurance companies for the purpose of effectuating a settlement of the assigned claim.

IN WITNESS WHEREOF, I have signed this instrument this _____ day of _____ 19_____.

_____
(Signature)

I accept and agree that I will submit the decision of the United States Postal Service to arbitration if I refuse to accept the foregoing settlement of claim as pursuant to the authority granted by 39 C.F.R. 304.2(b) of the Postal Regulations. I further agree to accept the above assignment.

Dated: _____

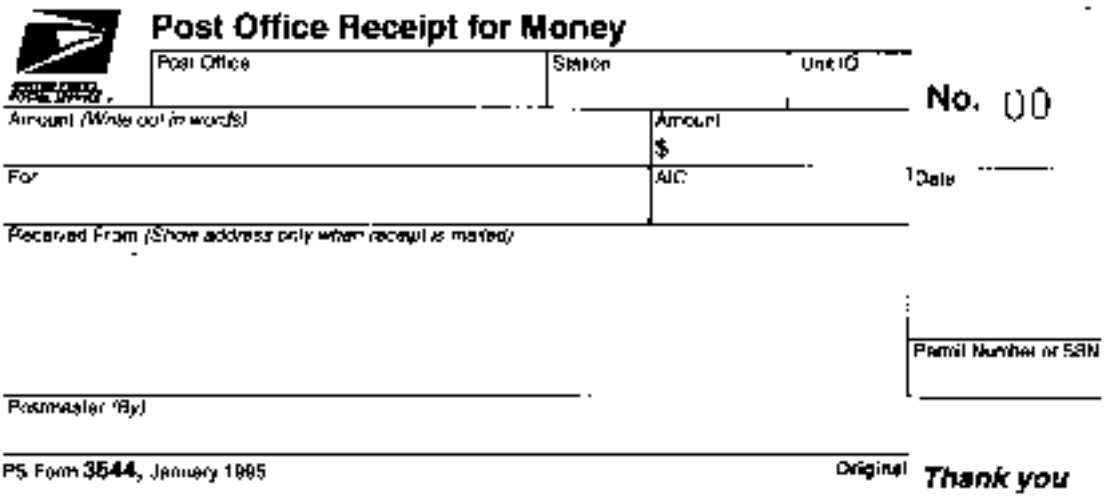
_____
(Signature)

_____
(Title)

Witness for Claimant

Public burden statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The estimated time for completing this form is 30 minutes. This information is required to obtain benefits. Completion of this form is voluntary; however, if you do not provide the information requested on this form, the USPS may not be able to process your claim properly or act on your behalf.

Form 3544



Post Office Receipt for Money

Post Office | Station | Unit ID

No. 00

Amount (Write out in words)

Amount
$

For

AIC

Date

Received From (Show address only when receipt is mailed)

Permit Number or SSN

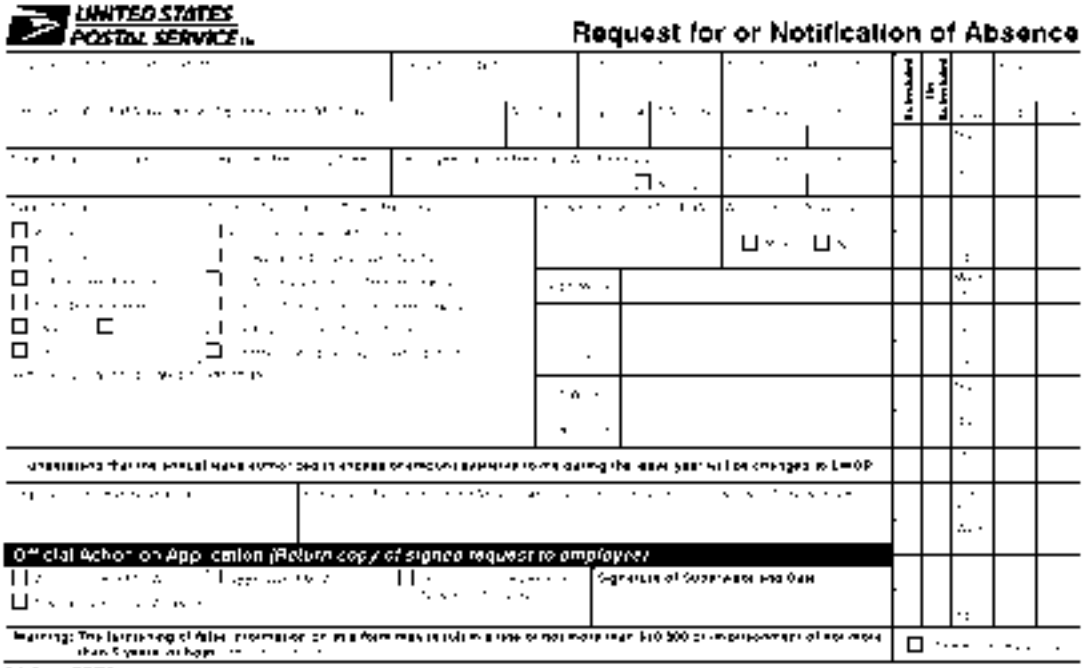
Postmaster (By)

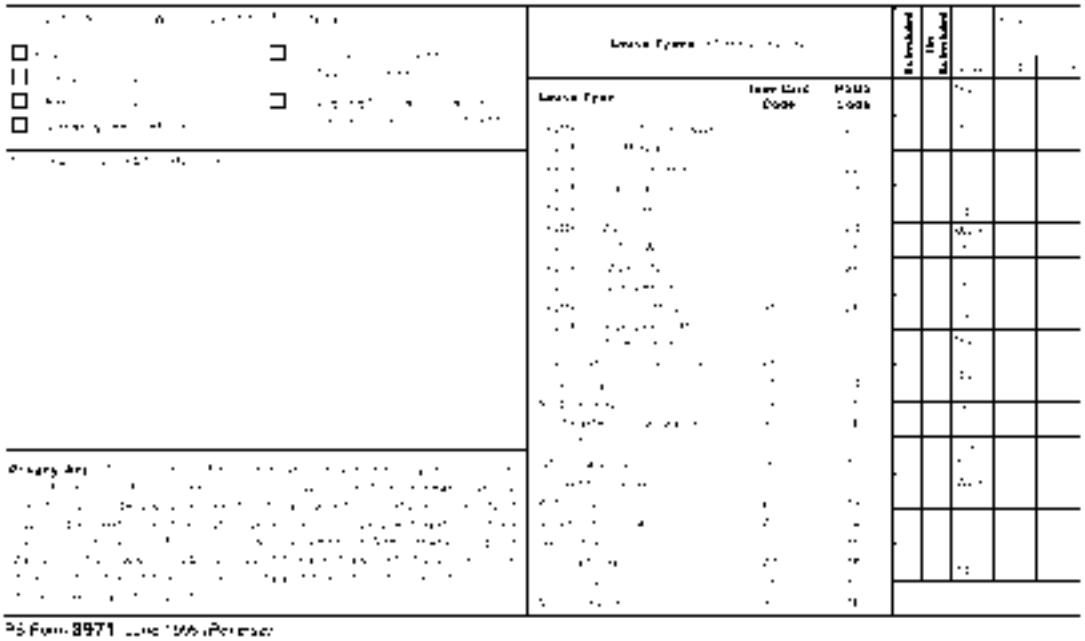
PS Form **3544**, January 1995

Original

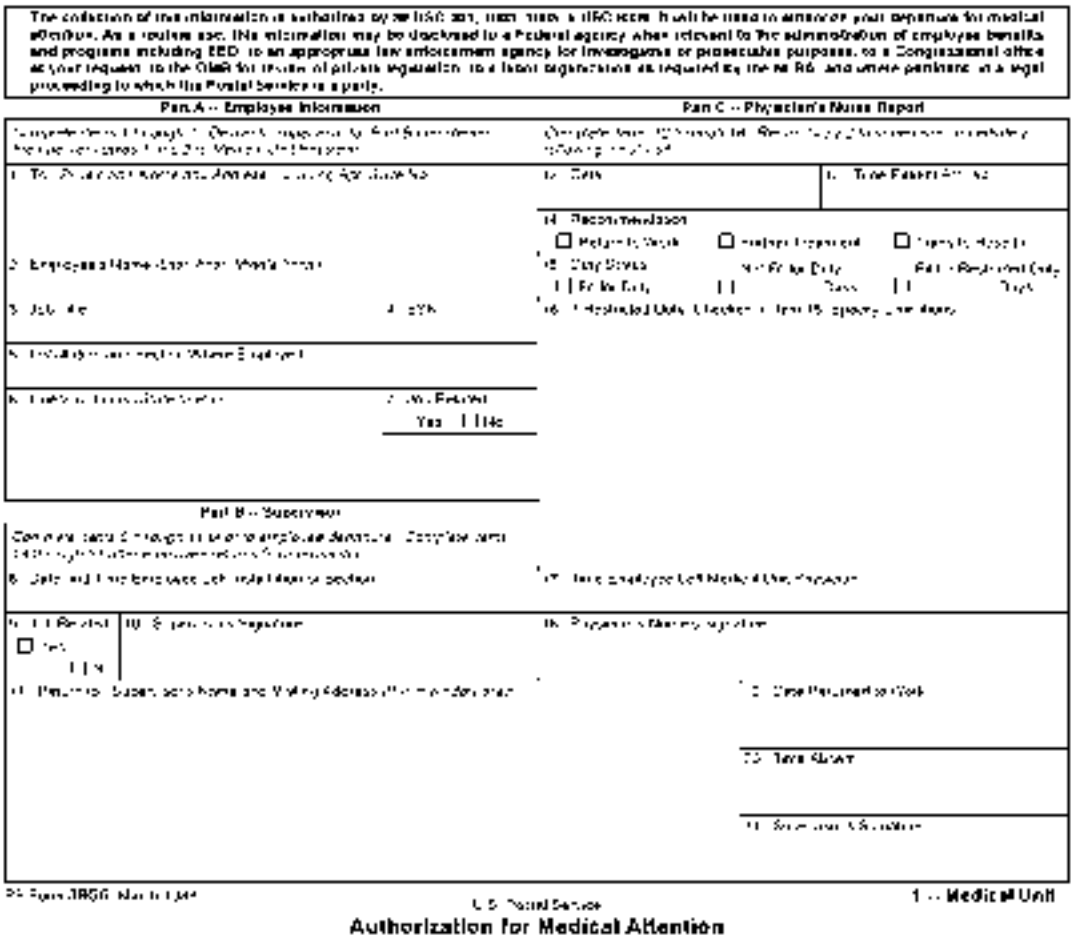
Thank you

Form 3971


UNITED STATES POSTAL SERVICE
Request for or Notification of Absence



Form 3956



The collection of this information is authorized by section 1207, title 5, USC. Your SSN will be used to administer your response to medical attention. As a routine use, this information may be disclosed to a Federal agency when relevant to the administration of employee benefits and programs including EEO, to an appropriate law enforcement agency for investigative or prosecutive purposes, to a Congressional office at your request, to the OMB for review of private legislation, to a labor organization as required by the NLRA, and where pertinent, in a legal proceeding to which the Postal Service is a party.

Part A -- Employee Information

Part C -- Physician's Notes Report

Part B -- Supervisor

U.S. Postal Service

Authorization for Medical Attention

1 -- Medical Unit

Form 6105

UNITED STATES POSTAL SERVICE

Disclosure of Information About Employees to Collective Bargaining Agents

Notice

This information is being disclosed under the provisions of a Collective Bargaining Agreement for official collective bargaining purposes as being relevant to the issue which you have addressed. As the receiving union official, you are hereby notified that the records include personal information about individuals in the custody of the Postal Service. This information has been protected under the Privacy Act. Its use by your organization should be consistent with the statutory protections. Specifically, this information should not be disclosed or discussed with anyone except as necessary for an official collective bargaining purpose. Illegal access to, or disclosure and dissemination outside of proper procedure of personal information by any employee regarding the subject matter of this notice may result in specific individuals who are receiving information they do not need to know.

PS Form 6105, May 1995 — Postal Service Representative and Second Participant

UNITED STATES POSTAL SERVICE

Disclosure of Information About Employees to Collective Bargaining Agents

Disclosure Accounting Statement

In compliance with the Privacy Act of 1974, an accounting of disclosure must be kept whenever a personal record is disclosed. Give additional information below.

Name of Employee (Subject of Record) Disclosed

Date of Disclosure

Stated Purpose	Source (Person or Office Requesting)

I have received (but not the information) and understand the conditions as set forth herein.

Date

Signature

Name
Title
Local
Union

Instructions to Supervisor or Other Disclosing USPS Official

Postal Service regulations implementing the Privacy Act and the collective bargaining agreement provide for notifying bargaining representatives of the identity of employees whose records have been disclosed to persons outside the Postal Service. Use this form for that purpose.

When a union agent asks for information, a signed statement of authorization is required from the employee(s) who is the subject of the request. In addition, you may release information about employees only for the purposes listed on the reverse side of this form. Information will not be released unless the employee's specific written consent is received before the information is released.

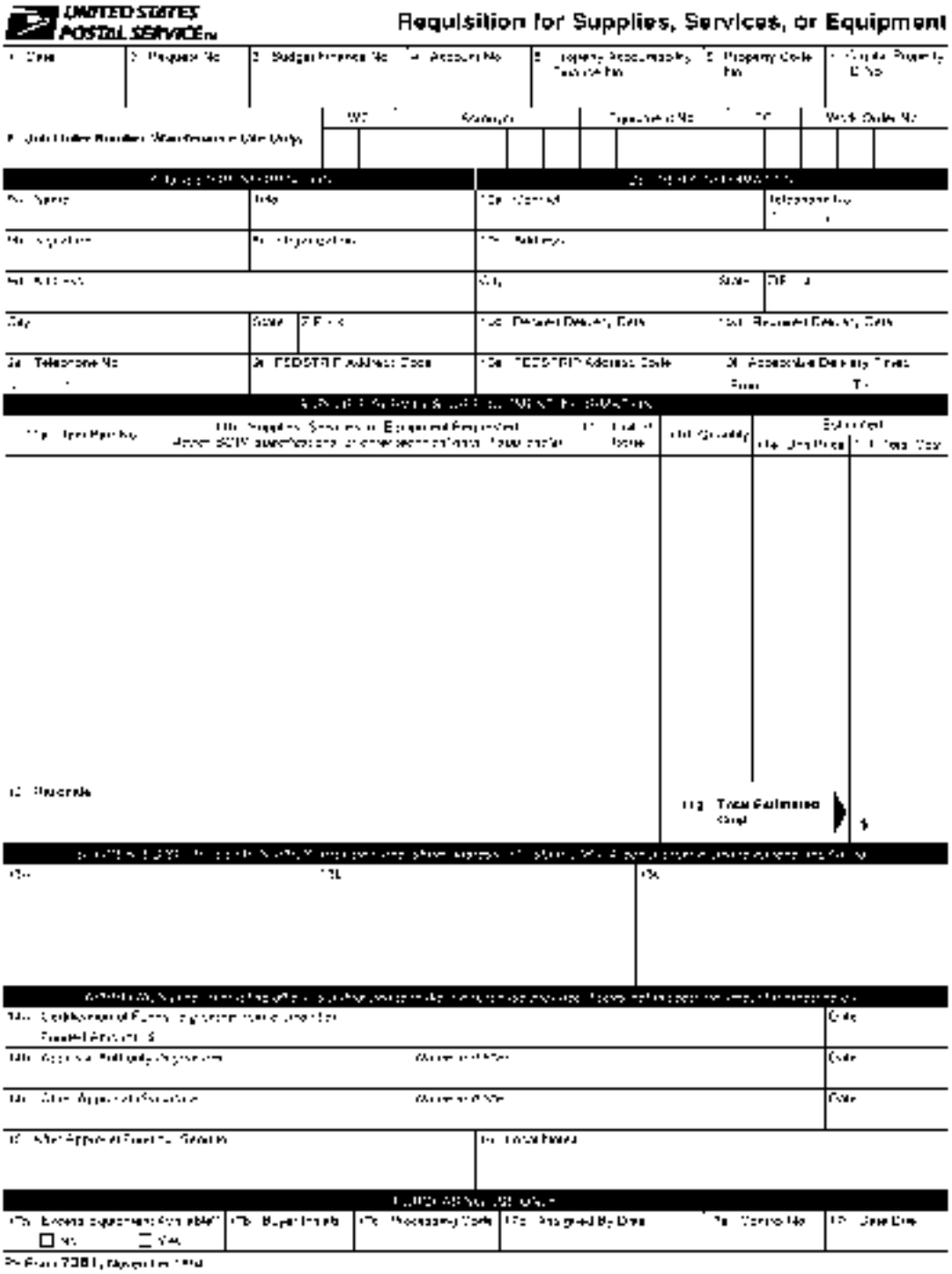
You should:

1. Inquire as to the purpose of the request.
2. Determine whether release of information is the subject of a grievance or other administrative proceeding.
3. Release information only for purposes listed on the reverse side of this form.
4. Release information only to the union official who requested it.
5. Release information only to appropriate Human Resources personnel as appropriate. (Do not use fax or Internet.)
6. Limit the release to specific items and avoid the release of unnecessary information.
7. Make a photocopy of the signed authorization and keep with the record that was released.
8. Be sure to tell the union official not to disclose information to anyone else.

NOTE: Employees have the right to request an accounting of disclosures of their records. Keep a copy of this form for that purpose. Refer requests to the Privacy Act Officer.

PS Form 6105, [illegible] — Postal Service Representative Accompanying Employee

Form 7381


UNITED STATES POSTAL SERVICE

Requisition for Supplies, Services, or Equipment

1 Date	2 Request No.	3 Budget Reference No.	4 Account No.	5 Property Accountability Yes/No	6 Property Code No.	7 Property ID No.

8 Project Code Number (Maintenance Only)	WO	Work Order No.	Equipment No.	CC	Work Order No.

9 Requisitioner	Title	10 Requested	Telephone No.

11 Requisitioning Office	12 Delivery Point	13 Address

14 Mail Address	15 City	State	ZIP + 4

16 City	State	ZIP + 4	17 Desired Delivery Date	18 Required Delivery Date

19 Telephone No.	20 FEDSTRIP Address Code	21 FEDSTRIP Address Code	22 Acceptable Delivery Days From To

23 Type Item No.	24 Supplies, Services or Equipment Required (Include SCAC specifications, shipping weight and cubic)	25 Unit of Issue	26 Quantity	Estimated 27 Unit Price	28 Total Cost

29 Remarks

30 Total Estimated Cost $

31 Charge To	32	33

34 Requisitioner (Type name, sign, and title)	Date
35 Approved/Disapproved (Type name, sign, and title) (Maximum $)	Date
36 Other Approval Required (Type name, sign, and title) (Maximum $)	Date
37 Other Approval Required (Type name, sign, and title)	38 Funds Certified

39a Excess Equipment Available? ☐ No ☐ Yes	39b Buyer Initials	39c Processing Code	39d Assigned By Date	39e Control No.	39f Issue Date

PS Form 7381, [illegible]

Form 7381 (continued)

Instructions

General Information

1 Enter the date.
2 Enter the full two digits of the year of fiscal year and the next available requisition number (0001-9999).

Fiscal Information

3 Enter the appropriate account number (XXXXX) (Example: 40000) (optional).
4 Enter the property area activity location where you want the item to be delivered (Example: Building 20).
5 Enter the property type number of item requested (see Handbook 7.1, Property Type Numbers).
6 Enter the expiration date. (Example: If the item will be stored for 3 years, enter expiration date 3 years from today's date.)
7 Enter the job order number (JON) or appropriate accounting data.

Requestor Information

8 You, the requestor, must provide the following information:

a Your name (print).
b Your signature.
c Your organization name (Example: Accounting).
d The organization's mailing address (Example: 123 Main Street, Anytown, USA 12345).
e Your telephone number including area code and
f The FED STRIP address code of the requesting office.

Delivery Information

9 You must provide the following delivery information:

a Who should be contacted to answer questions concerning delivery and/or receipt (telephone number and area code).
b The complete address of the point of destination where the delivery is to take place (Example: Room 123, Building 20, Main Street).
c The desired delivery date. This is the optimal date when the goods or services could be received.
d The required delivery date. This is the date by which the goods or services must be delivered.
e The earliest acceptable date of the needs to commence when the item will be delivered, and
f The acceptable delivery times. These are the hours during which personnel will be available to accept the delivery.

Supplies, Services or Equipment Information

10 If you are requesting more than one type of item, use a separate line for each type. If applicable, provide part numbers. If you want the item to be delivered from GSA, indicate so here. If applicable, provide a general description of the service or equipment required and attach any statements of work specifications or other technical information needed to process the purchase.

a If applicable, enter the item's part number.
b If you have access to item's part number, request a purchase only the name of the item. Otherwise provide a brief description. Enter required quantity, unit of measure. Enter the unit price (if known).
c Enter the total price (if known).
d Enter the requested delivery date (if known).
e Enter the requested delivery point (if known).
f Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
g Enter the requested delivery point (if known).
h Enter the requested delivery date (if known).
i Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
j Enter the requested delivery point (if known).
k Enter the requested delivery date (if known).
l Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
m Enter the requested delivery point (if known).
n Enter the requested delivery date (if known).
o Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
p Enter the requested delivery point (if known).
q Enter the requested delivery date (if known).
r Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
s Enter the requested delivery point (if known).
t Enter the requested delivery date (if known).
u Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
v Enter the requested delivery point (if known).
w Enter the requested delivery date (if known).
x Enter the name of the item. Provide a brief description of the item. If the item is a commercial item, provide a brief description.
y Enter the requested delivery point (if known).
z Enter the requested delivery date (if known).

Reasons

12 Provide a brief explanation of why the supplies, services or equipment are needed.

Suggested Sources of Supply

13 Provide three (3) possible names, addresses and telephone numbers of suppliers (optional). If you have a specific supplier in mind, enter that supplier's name, address and telephone number. If you have no suggested sources, enter "none" or "any" and explain why.

Approvals

14 Obtain the appropriate approvals.

a The individual authorized to approve the purchase requisition must also approve the item.
b The individual with authority to approve the purchase requisition and the property item must be the same.
c If further approval is necessary, the appropriate authority signs here and also provides his or her name and date. If any other approvals are required, obtain and attach them to this form.

After Approval Funding Send to:

15 Enter the name (or initials) of the purchasing agent/person who is to actually purchase the supplies, services or equipment required.

Local Rules

16 Use this space to enter any information or data you deem necessary.

Purchasing Use Only

17 These items may be filled in only by purchasing personnel.

a Indicate whether the item may be obtained through stores.
b The type buying (the category that most applies to the item).
c Enter the (category of item) purchase method.
d The contracting officer must enter his or her name and date of purchase here.
e Enter the GOVERNMENT source.
f Enter the date the purchase was made.

OWCP Form 1500a

Data No. 1218-0056
Expires: 06-30-99

Instructions for Completing OWCP 1500 Health Insurance Claim Form For Medical Services Provided Under the FEDERAL EMPLOYEE'S COMPENSATION ACT (FECA) and the Federal BLACK LUNG BENEFITS ACT (FBLBA)

GENERAL INFORMATION: FEDERAL EMPLOYEES COMPENSATION CLAIMANTS

Claims filed under the Federal Employees' Compensation Act (FECA) (5 USC 8101 et seq.) are for employment-related illness or injury. All services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation, may be furnished. "Physician" includes all Doctors of Medicine (M.D.s), podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct subluxation as demonstrated by X-ray to exist.

FEES

The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) is responsible for payment of all reasonable charges stemming from covered medical services to claimants eligible under FECA. OWCP employs a relative value scale fee schedule and other tests to determine reasonableness. Schedule limitations are applied through an automated billing system that is based on the identification of procedures as defined in the AMA Current Procedural Terminology (CPT). Correct CPT code and modifier(s) is required. Incorrect coding will result in inappropriate payment. For specific information about schedule limits call the Department of Labor's Federal Employees' Compensation (FEC) office which services your area.

REPORTS

A medical report which indicates the dates of treatment, diagnosis(es), findings, and type of treatment rendered is required for services provided by a physician (as defined under the Act). The initial report should explain relationship of the injury or illness to the employment. Test results and x-ray findings should accompany billings.

GENERAL INFORMATION: FEDERAL BLACK LUNG BENEFITS ACT (FBLBA) CLAIMANTS

The Federal Black Lung Benefits Act (30 USC 901 et seq.) covers medical services to eligible beneficiaries for diagnostic and therapeutic services for black lung disease as defined under the Act. For specific information about reimbursable services, call the Dept. of Labor's Black Lung office that services your facility or call the National Office in Washington, D.C.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION

The OWCP is authorized (FECA 5 USC 8101 et seq; FBLBA 30 USC 901 et seq.) to collect information needed to administer the FECA and the FBLBA. The information collected is used to identify the eligibility of the claimant for benefits, and determine coverage of services provided. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amounts charged will prevent payment of the claim. Failure to supply other information, such as claim number or use of ICD or CPT codes, will delay payment or may result in rejection of the claim because of incomplete information.

SIGNATURE

Your signature in Item 31 indicates your agreement to accept the Government's charge determination on covered services as payment in full and indicates your agreement not to seek reimbursement from the patient of any amounts not paid by OWCP for covered services as the result of the application of its fee schedule or related tests for reasonableness (appeals are allowed).

Your signature in Item 31 also indicates that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered or were rendered incident to your direct order. Your signature indicates that you understand that any false claims, statements or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

FORM SUBMITTAL

FECA: Send all forms for FECA to the appropriate Federal Employees' Compensation District Office, or to the patient's employing federal agency for forwarding to the correct address.

FBLBA: All forms for services provided under the FBLBA should be returned to the Federal Black Lung Program, P.O. Box 740, Lanham, MD 20706, unless otherwise instructed.

INSTRUCTIONS FOR COMPLETING THE FORM

A brief description of each data element and its applicability to requirements under FECA and FBLBA (Black Lung) are listed below. For additional information contact the U.S. Department of Labor.

Item 1. Check the name of the program being billed.

Item 1a. Enter patient's social security number.

Item 2. Enter the patient's last name, first name, middle initial.

Item 3. Enter the patient's date of birth (MMDDYY).

Item 4. For FECA: leave blank.
For Black Lung: complete only if patient is deceased and this medical bill was paid by a survivor. Enter the name of the survivor to whom medical payment is due.

Item 5. Enter the patient's address (Street address, city, state, ZIP Code, telephone number is optional).

Item 6. Leave blank.

Item 7. For FECA: leave blank.
For Black Lung: complete if Item No. 4 was completed. Enter the address of survivor to whom payment is due.

OWCP-1500a
April 1992

OWCP Form 1500a (continued)

Item 8 Leave blank

Item 9 Complete "Yes-No" if "Yes" is "yes". List any potential third party payors other than FECA or Black Lung. This includes other federal programs (Medicaid, Medicare, CHAMPUS, etc.) and any private policy. Include policy number and policy holder's name.

Item 10 For FECA, check the appropriate boxes (under 10a - 10c. For Black Lung, not required.

Item 11 For FECA, enter the patient's claim number. OMISSION WILL RESULT IN DELAYED BILL PROCESSING. For Black Lung, leave blank.

Item 11a. Leave blank.

Item 11b For FECA, enter the name of the federal employing agency. For Black Lung, leave blank.

Item 11c Leave blank.

Item 11d. Check the appropriate box. If "Yes" is checked, list any potential third party payors under Item No. 9.

Item 12 The signature of the patient or authorized representative authorizes release of the medical information necessary to process the claim, and requests payment. Signature is required; mark (X) must be co-signed by a witness and relationship to patient indicated.

Item 13 Signature indicates authorization for payment of benefits directly to the provider. Acceptance of this assignment is considered to be a contractual arrangement. The "authorizing person" may be the beneficiary (patient) eligible under the program billed, person with power of attorney, or a statement that the beneficiary's signature is on file with the billing provider.

Item 14. For FECA, enter date of injury or first symptom. For Black Lung, not required.

Item 15. For FECA, enter first date of similar illness, injury or symptoms. For Black Lung, not required.

Item 16 For FECA, enter dates (MM/DD/YY) patient is unable to work in current occupation. For Black Lung, leave blank.

Item 17. and 17a. If this is a referral, enter full name and I.D. of referring physician.

Item 18 If services were provided during an inpatient hospital stay, enter the inpatient service days covered.

Item 19. Use for additional information (see Item 24).

Item 20. Must be completed if laboratory service charges are included on the bill. Check "YES" if the services were performed outside the physician's office, and enter the amount charged. Enter the name and address of the person/facility providing the services in Item No. 32 with an "I". If an independent laboratory is billing, indicate where the sample was taken in 24b.

Item 21. Enter the diagnosis(es) of the condition(s) being treated using current ICD codes. Enter codes in priority order (primary, secondary, condition). Coding structure must follow the International Classification, Clinical Modification, 9th revision or the latest revision published. A brief narrative may also be entered but not substituted for the ICD code.

Item 22. Leave blank.

Item 23 If a prior authorization number has been assigned, provide that number; otherwise leave blank.

Item 24 In Column A, enter month, day and year (MM/DD/YY) for each service/occupation provided. If the "from" and "to" dates represent a series of identical services, enter the number of services provided in column "G".

Column B: enter the correct HCFA/OWCP standard "place of service" code (see HCFA manual).

Column C: not required.

Column D: enter the applicable five digit AMA CPT (current edition) code and applicable modifier(s), the HCPCS, or the OWCP generic procedure code; enter a brief narrative in columns "J and K".

Column E: enter the diagnosis reference number (1,2,3 or 4, in Item No. 21) to relate the date of service and the procedure(s) performed to the appropriate ICD code, or enter the appropriate ICD code.

Column F: enter the total charge(s) for each listed service(s). Describe any unusual circumstances in column "J" and "K" or attach report to avoid processing delays.

Column G: enter the number of services/units provided for period listed in column "A".

Column "H": Leave blank.

Column "I": Enter "YES" if an emergency service.

Column "J" and "K": use for nomenclature or notes.

Item 25. Enter the federal tax I.D. or social security number to which the payment will be assigned.
THIS ITEM MUST BE COMPLETED FOR PAYMENT TO BE PROCESSED.

Item 26. See the notes on FECA, FSLBA and Signature.

Item 27. Enter the total charges from column "F".

Item 28. If any payment has been made, enter that amount here.

Item 29. Enter the amount due (Item 27 less Item 28).

Item 30. Enter the balance now due.

Item 31. Signature is required. Print name if not typed in items 9c or 33. For Black Lung, Mechanical reproduction is acceptable.

Item 32. Complete as appropriate: (1) if address is different than that in Item No. 33, (2) if Item No. 20 applies, (3) if other circumstances apply.

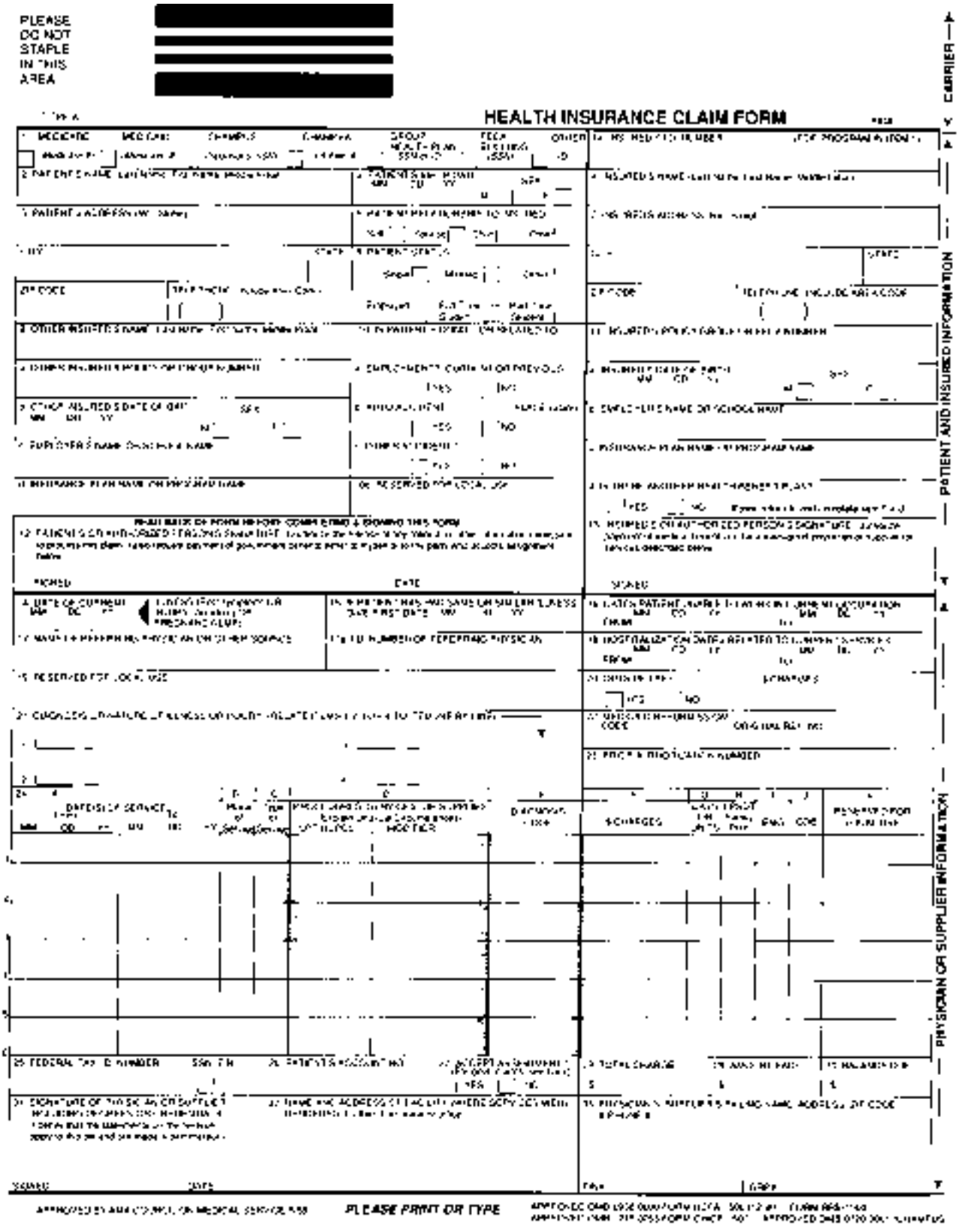
Item 33. Enter (1) the name and address to which payment is to be made, and (2) your PIN and Group number (if member).
FOR BLACK LUNG in the space following "GRP #", enter your BLACK LUNG SIX-DIGIT FSLBA assigned provider number.
FAILURE TO ENTER THIS NUMBER WILL DELAY PAYMENT OR CAUSE REJECTION OF THE BILL FOR INCOMPLETE/INACCURATE INFORMATION.

Public Burden Statement

We estimate that it will take an average of ten to fifteen minutes to complete the information required on this form. This includes reviewing of instructions, researching information from the patient's records and entering the data onto the form. This time is based on familiarity with standardized coding structures and previous use of the common form. Send comments regarding this burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to the Office of IRM Policy, Department of Labor, Room N-1301, 200 Constitution Avenue, NW, Washington, DC 20210 and to the Office of Management and Budget, Paperwork Reduction Project (1215-0055), Washington, DC 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

OWCP Form 1500



OWCP Form 3

Injured Worker's Rehabilitation Status Report

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

1. Injured Worker's Name (First, Middle, Last)	2. Date of Injury	3. Claimant's No. (LHWCA)	4. OWCP No.

5. Check the injured worker's status and status dates. Check special information when required by the status, for closures and as appropriate. Justify each status change or extension in the comments section.

	STATUS	SPECIAL INFORMATION
	From _____ To _____	
REFERRAL	☐ Early (Check a) ☐ Other (Check a) ☐ Initial Interview Held By OWCP Rehabilitation Specialist (Check d)	☐ a. Date compensation file screened _____ ☐ b. Date OWCP-8 or 13 sent _____ ☐ c. Date OWCP-10 or 11 sent _____ ☐ d. Date of initial interview by RS _____ ☐ e. Other (See Comments)
ACTIVE	☐ Plan Development (Check a or b and c) ☐ Medical Rehabilitation ☐ Training (Check d, e, or f) ☐ Self-Employment ☐ Placement-New Employer ☐ Placement-Previous Employer ☐ Employed (Check g) ☐ Service Interrupted ☐ Post-Employment Service	☐ a. Testing required (☐ Yes ☐ No) ☐ b. Testing waived (See Comments) ☐ c. Work evaluation required (☐ Yes ☐ No) ☐ d. Pre-vocational training ☐ e. Vocational training ☐ f. On-the-job training ☐ g. Date employed _____ (See Comments) ☐ h. Reopened (See Comments) ☐ i. Other (See Comments)
CLOSED	☐ Closure Date ☐ Referral (Indicate Reason Code) ☐ Closed Rehabilitated - New Employer ☐ Returned to Work - Referral Screening ☐ Closed Rehabilitated - Previous Employer ☐ Closed Other (Indicate Reason Code) ☐ Closed with Post Employment Services ☐ Returned to Work - Without OWCP Assistance ☐ Returned to Work - With Claims Examiner Assistance ☐ Returned to Work - Assisted Reemployment Program ☐ Returned to Work - Nurse Intervention Program	☐ a. Compensation Terminated ☐ b. Refused Services ☐ c. Not able to Work ☐ d. Retired ☐ e. Settled Case ☐ f. Transferred to Another District Office ☐ g. Other ☐ h. Not Able to Work - Nurse Intervention ☐ i. Not Able to Work - Assisted Reemployment Program ☐ j. Suitable Job Selected - Not Placed

6. Vocational Rehabilitation Counselor (Complete item 6a when referring to a new VRC)

a. Name	b. Professional hours approved for the status (See Item 5)

c. The VRC's proposed status is ☐ Accepted ☐ Modified ☐ Rejected (See Comments) ☐ Extended to _____

7. Comments:

8. OWCP Rehabilitation Specialist	9. Telephone No.	10. Date

Copy Distribution: WHITE - Carrier/Employer YELLOW - Worker/Attorney PINK - Dist. R-File Form OWCP-3
CANARY - Comp. File GREEN - VR Counselor Rev. Mar. 1991

OWCP Form 5a

Work Capacity Evaluation
Psychiatric/Psychological Conditions

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

OMB No. 1215-0103
Expires 05-31-96

Injured worker's name (First, middle, last) _____ (OWCP No. _____

Dear Doctor _____,

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions: _____

Our Office administers the Federal Employees' Compensation Act (FECA) and the Longshore and Harbor Workers' Compensation Act (LHWCA) which provide workers' compensation payments and medical benefits to employees injured during the performance of duty. The rehabilitation and the return to work of the injured worker are major objectives of our Office. Your assessment will enable OWCP to identify the patient's level of function. We will then attempt to match his or her functional capacity to existing jobs or to recommend the modification of an existing position if necessary. Should you like to discuss these questions or related aspects of the case with OWCP staff please contact _____ at _____.
Thank you for your interest in this case.

In completing this form, you should first consider only those diseases which the Office has accepted as related to employment, as noted above.

Conditions which are not accepted by our Office, but which, in your opinion, affect the occupational capacity of the patient can be mentioned in item 14. If necessary, additional narration can be appended to this questionnaire.

If both a work-related and a non-industrial condition affect the ability to perform a task, so specify in items 1-12.

In addition, when completing items 1-12, you should answer affirmatively if the patient can perform the function PARTIALLY, using the space provided to delineate any limits and/or needed accommodations. Only if the patient is not able to perform the function at all should the question be answered in the negative.

QUESTIONS: Can This Person:	Answer:	Comments:
1. Work in his or her usual workplace?	☐ Yes ☐ No	
2. Communicate clearly with others by telephone?	☐ Yes ☐ No	
3. Communicate clearly with others face to face?	☐ Yes ☐ No	
4. Participate actively in group/team activities?	☐ Yes ☐ No	
5. Cooperate with co-workers?	☐ Yes ☐ No	
6. Respond appropriately to persons in authority?	☐ Yes ☐ No	
7. Interact in a public situation, such as in a hotel or cashier position?	☐ Yes ☐ No	
8. Organize work and complete tasks without supervision?	☐ Yes ☐ No	
9. Organize work and complete tasks with supervision?	☐ Yes ☐ No	
10. Maintain concentration and pace at acceptable levels?	☐ Yes ☐ No	
11. Perform high volume work?	☐ Yes ☐ No	
12. Adapt to stressful work situations, e.g. meetings, deadlines, shifting priorities, changes in routine?	☐ Yes ☐ No	

SEE REVERSE

Form OWCP-5a
Rev. Sept. 1995

OWCP Form 5a (continued)

13. If the patient is receiving medication(s) for his or her psychiatric condition, are side effects likely? If so, what are the expected signs and symptoms and how will they impact on the patient's ability to work?

14. Please provide any additional psychiatric/psychological information in this case which may be important for the rehabilitation effort.

15. What is the date of maximum medical improvement?

16. Physician's Name (print or type)

17. Signature

18. Date

Public Burden Statement

We estimate that it will take an average of 45 minutes per response to complete this information collection, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

OWCP Form 5b

Work Capacity Evaluation
Cardiovascular/Pulmonary Conditions

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

Injured worker's name (First, middle, last) OWCP No. OMB No. 1215-0103 Expires 09-30-96

Dear Doctor _____,

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions: _____

Our Office administers the Federal Employees' Compensation Act (FECA) and the Longshore and Harbor Workers' Compensation Act (LHWCA), which provide workers' compensation payments and medical benefits to employees injured during the performance of duty. The rehabilitation and the return to work of the injured worker are major objectives of our Office. Your assessment will enable OWCP to identify the patient's level of function. We will then attempt to match his or her functional capacity to existing jobs or to recommend the modification of an existing position if necessary. Should you like to discuss these questions or related aspects of the case with OWCP staff please contact _____ on _____.
Thank you for your interest in this case.

In completing this form, you should first consider only those diseases which the Office has accepted as related to employment as noted above.

Conditions which are not accepted by our Office, but which, in your opinion, affect the functional capacity of the patient can be mentioned in item 5. If necessary, additional narration can be appended to this questionnaire.

If both a work-related and a non-industrial condition affect the ability to perform a task, so specify in items 1-5.

In addition, when completing items 1-5, you should answer affirmatively if the patient can perform the function PARTIALLY, using the space provided to delineate any limits and/or needed accommodations. Only if the patient is not able to perform the function at all should the question be answered in the negative.

The results of clinical tests and/or protocols can be used in this assessment; however, please relate the test results to the physical activities mentioned in the questionnaire. Similarly, if a functional classification is used in the narration, the functional class assigned to the patient must be fully described.

QUESTIONS:

1. Are there limitations in this person's capacity to engage in activities involving strenuous physical exertion such as climbing two or more flights of stairs, running, lifting, carrying heavy weights, etc.? Yes ☐ No ☐
If so, please note limitations including specific data such as number of pounds, flights of stairs, etc.:

_____

_____

_____

_____

_____

_____

SEE REVERSE

Form CWCP-5b
Rev. Sept. 1993

OWCP Form 5b (continued)

2 Are there limitations in the patient's ability to perform common physical activities which do not require heavy physical exertion, such as bending, kneeling, squatting, and standing? Yes ☐ No ☐
If so, please detail limitations.

3 Has the work injury/condition caused anatomical and/or functional changes in the cardiovascular or respiratory systems that precude exposure to

a. temperature extremes Yes ☐ No ☐
b. airborne particles (dust, etc.) Yes ☐ No ☐
c. gases/fumes Yes ☐ No ☐
d. electromagnetic pulses (radars, radio waves, etc.) Yes ☐ No ☐

4. Can this person work in stressful situations, e.g. high volume work, meeting deadlines, shifting priorities?
Yes ☐ No ☐
Please explain

5 Are there any other medical factors which need to be considered in the identification of a position for this person? Please explain and specify whether these factors are related to the work injury or not.

6 What is the date of maximum medical improvement?

7 Physician's name (print or type)

8. Signature

9. Date

Public Burden Statement

We estimate that it will take an average of 20 minutes per response to complete this information collection, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of the Policy, U.S. Department of Labor, Room N-3301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0031), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

OWCP Form 5c

Work Capacity Evaluation
Musculoskeletal Conditions

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

Injured worker's name (First, Middle, last) _____ OWCP No. _____ OMB No. 1215-0103
Expires: 09-30-98

Dear Doctor _____

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions: _____

This Office administers the Federal Employees' Compensation Act (FECA) and the Longshore and Harbor Workers' Compensation Act (LHWCA), which provide workers' compensation payments and medical benefits to employees injured during the performance of duty. The rehabilitation and the return to work of the injured worker are major objectives of our Office. Your assessment will enable OWCP to identify the patient's level of function. We will then attempt to match his or her functional capacity to existing jobs or to recommend the modification of an existing position if necessary. Should you like to discuss these questions or related aspects of the case with OWCP staff please contact _____ at _____.
Thank you for your interest in this case.

In completing this form, you should first consider only those diseases which the Office has accepted as related to employment as noted above.

Conditions which are not accepted by our Office, but which, in your opinion, affect the functional capacity of the patient can be mentioned in Item 8. If necessary, additional narrative can be appended to this questionnaire.

If both a work-related and a non-industrial condition affect the ability to perform a task, so specify in Items 1-8.

In addition, when completing Items 1-8, you should answer affirmatively if the patient can perform the function PARTIALLY, using the space provided to delineate any limits and/or needed accommodations. Only if the patient is not able to perform the function at all should the question be answered in the negative.

QUESTIONS:

1. This patient should limit the following activities:

_____
(e.g., kneeling, standing, bending, pulling, reaching, lifting)

2. For those activities which should be limited, indicate applicable restrictions:

_____
(e.g., weight, times per hour, hours per day, minutes per hour)

3. With the above limitations observed, patient may work _____ hours per day.

_____

Form OWCP-5c
Rev. Sept. 1989

OWCP Form 5c (continued)

4. Are there limitations in the fine motor movements of the upper extremities? Yes ☐ No ☐
If so, please describe.

5. Can this patient perform repetitive motions of the wrist? Yes ☐ No ☐

of the elbow? Yes ☐ No ☐

If a limitation is present, please provide the total number of hours per day the motion can be performed and the length of time the activity can be performed before a break is needed. Indicate whether the restrictions apply to the one side only or whether they are bilateral.

6. Which of the above-described limitations are due to the employment injury?

Does the patient have any limitations due to pre-existing or non-work-related conditions? If so, please explain.

7. How long do you anticipate these restrictions will apply?

8. Are there any other medical factors which need to be considered in the identification of a position for this person? If so, please explain and specify whether or not those factors are related to the work injury.

9. Please provide the date that maximum medical improvement from the work injury was or will be reached.

10. Physician's Name (print or type)

11. Signature 12. Date

Public Burden Statement

We estimate that it will take an average of 30 minutes per response to complete this information collection, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of HRM Policy, U.S. Department of Labor, Room N-3301, 200 Constitution Avenue, N.W., Washington, D.C. 20210 and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES.

OWCP Form 6

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation
Room 800
800 North Capitol Street, N.W.
Washington, D.C. 20211

File Number:

202 724-0705

The medical reports in your file indicate that rehabilitation services may be of benefit to you. Our rehabilitation program can help you in your effort to return to suitable employment.

The purpose of our rehabilitation program is to help you return to work. I will do everthing possible to assist you in returning to work. Your medical condition may still be improving, but this may be a good time to begin planning your future.

Our first consideration is to help you to return to work with your previous employer in a job that you are vocationally and medically able to do. If your previous employer does not have a job that you are vocationally and medically able to do, we will help you return to work with a new employer. If placement is not possible without training because of your vocational or medical condition, training will be provided if it results in your return to work.

Please call me at 202 724-0705 Tues &Thurs -m and Wednesdayother days call me at 703 565-2274 to diacuss your future. If your call is long distance, I am unable to accept collect calls, due to a Federal regulation; however, if you leave your name, number, and a convenient time to return your call, I will call you as soon as possible. If you cannot call me, please send me a note with a telephone number where you can be reached and when you can be reached.

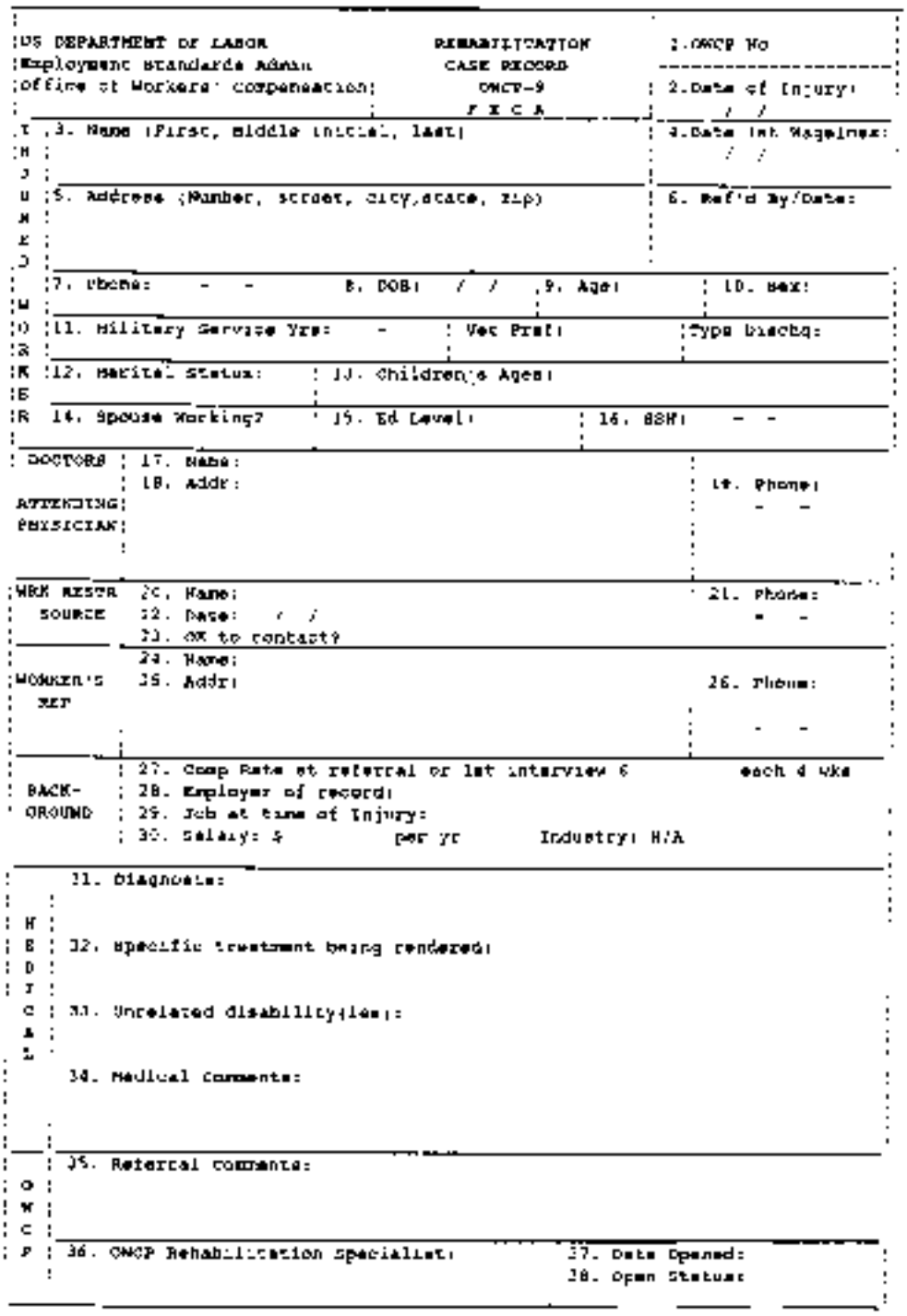
Thank you.

Sincerely,

Adina F. Leviton, RC/S
Vocational Rehabilitation Specialist

Working for America's Workforce

OWCP Form 6 (continued)


US DEPARTMENT OF LABOR
Employment Standards Admin
Office of Workers' Compensation

REHABILITATION CASE RECORD
OWCP-9
F E C A

1. OWCP No
2. Date of Injury: / /
3. Name (First, Middle Initial, Last)
4. Date Int Wageloss: / /
5. Address (Number, street, city, state, zip)
6. Ref'd By/Date:
7. Phone: - -
8. DOB: / /
9. Age:
10. Sex:
11. Military Service Yrs: -
Vet Pref:
Type Dischg:
12. Marital Status:
13. Children's Ages:
14. Spouse Working?
15. Ed Level:
16. SSN: - -

DOCTORS ATTENDING PHYSICIAN
17. Name:
18. Addr:
19. Phone: - -

WORK RESTR SOURCE
20. Name:
21. Phone: - -
22. Date: / /
23. OK to contact?

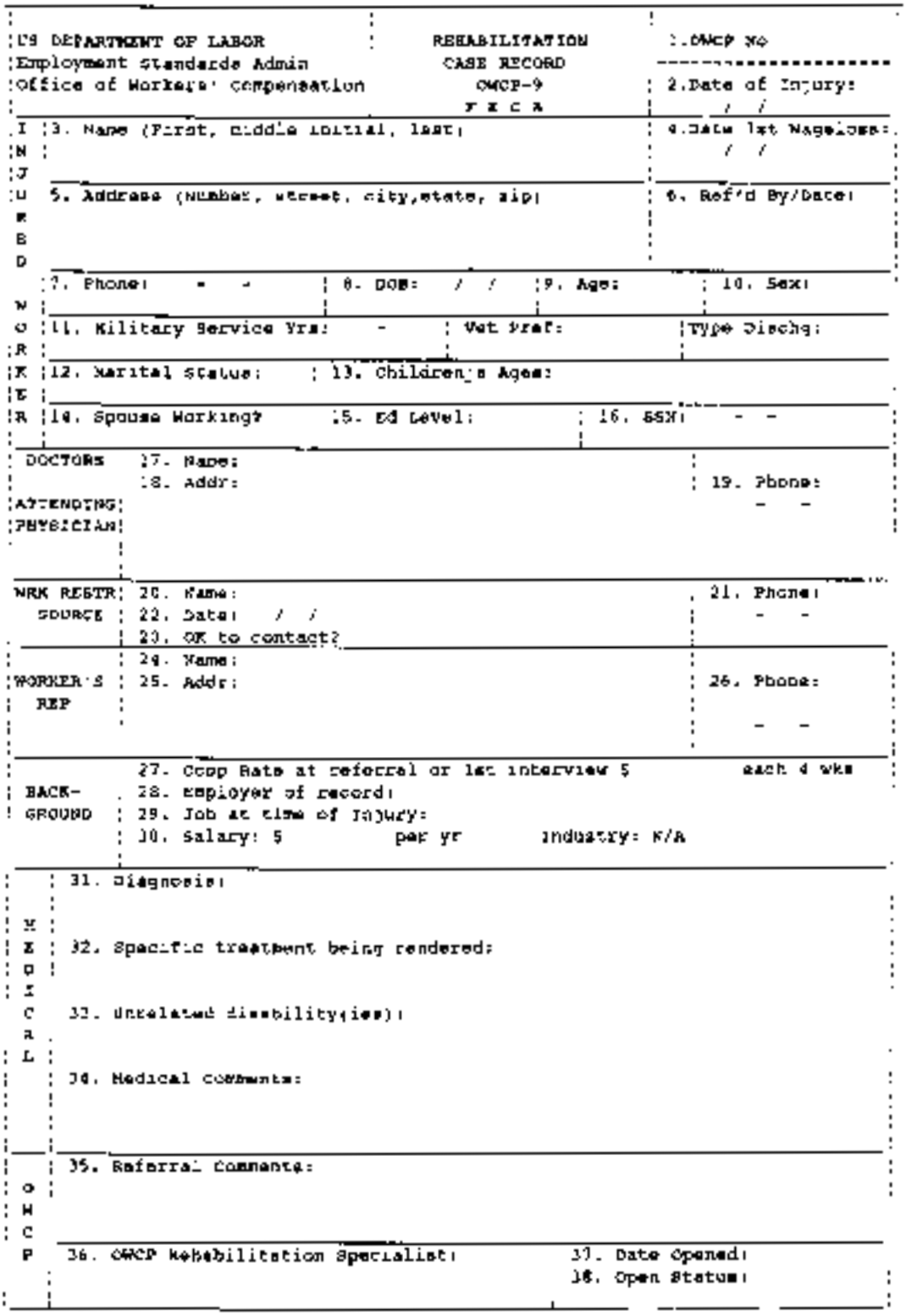
WORKER'S REP
24. Name:
25. Addr:
26. Phone: - -

BACKGROUND
27. Comp Rate at referral or 1st interview $ each 4 wks
28. Employer of record:
29. Job at time of Injury:
30. Salary: $ per yr Industry: N/A

MEDICAL
31. Diagnosis:
32. Specific treatment being rendered:
33. Unrelated disability(ies):
34. Medical Comments:

OWCP
35. Referral comments:
36. OWCP Rehabilitation Specialist:
37. Date Opened:
38. Open Status:

OWCP Form 9 Rehabilitation Case Record



US DEPARTMENT OF LABOR
Employment Standards Admin
Office of Workers' Compensation

REHABILITATION CASE RECORD
OWCP-9
F E C A

1. OWCP No
2. Date of Injury: / /

INJURED WORKER
3. Name (First, middle initial, last)
4. Date 1st Wageloss: / /
5. Address (Number, street, city, state, zip)
6. Ref'd By/Date:
7. Phone: - -
8. DOB: / /
9. Age:
10. Sex:
11. Military Service Yrs: -
Vet Pref:
Type Dischg:
12. Marital Status:
13. Children's Ages:
14. Spouse Working?
15. Ed Level:
16. SSN: - -

ATTENDING PHYSICIAN
17. Name:
18. Addr:
19. Phone: - -

WRK RESTR SOURCE
20. Name:
21. Phone: - -
22. Date: / /
23. OK to contact?

WORKER'S REP
24. Name:
25. Addr:
26. Phone: - -

BACKGROUND
27. Comp Rate at referral or 1st interview $ each 4 wks
28. Employer of record:
29. Job at time of Injury:
30. Salary: $ per yr Industry: N/A

MEDICAL
31. Diagnosis:
32. Specific treatment being rendered:
33. Unrelated disability(ies):
34. Medical comments:

OTHC
35. Referral Comments:

36. OWCP Rehabilitation Specialist:
37. Date Opened:
38. Open Status:

OWCP Letter 11

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

File No.

This Office has not received a response from you since we wrote you three weeks ago concerning your return to work effort.

We will assume you are not interested in rehabilitation services if you do not contact us at the above number within one week from the date you receive this letter. Our Office will take appropriate action with respect to your case.

Sincerely,

Division of Vocational Rehabilitation

Include your address, ZIP code, and file number on all correspondence

F.C.C. OWCP-11
Nov. 1979

OWCP Form 35 Routine Referral and Award

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation

File Number:
Employee:
Employer:

MR COUNSELOR
GENERIC COUNSELOR

Dear :

This letter serves as a referral and authorization to provide counseling, guidance, testing and placement services not to exceed $5,000 or two years from the date of this letter. It also serves as notification that you may refer the employee to the employer and as advice to both parties of their responsibilities in the reemployment process.

POLICY.

The Office of Workers' Compensation Programs (OWCP) is referring the employee to you for development of a possible vocational rehabilitation program. The OWCP is responsible for providing counseling and guidance, and making decisions on issues and benefits to insure the employee's prompt return to employment. Contact the employer for selective placement before considering a new employer. The employer is expected to act in good faith by making a reasonable effort to provide an appropriate job to the employee.

The employee's participation in vocational rehabilitation is compulsory under Section 8113(b) of the Federal Employees' Compensation Act. The Act provides benefits for wage loss if the injured worker must return to a lower paying job.

You are responsible for following the policies and procedures in OWCP's guidelines for rehabilitation services from vocational rehabilitation counselors, the standard in your agreement with OWCP, and the directions of the OWCP Rehabilitation Specialist (RS). The OWCP RS reserves the right to change or terminate your services, when it is in the best interest of the government.

OWCP Form 35 Routine Referral and Award (continued)

File Number
Employee:
Employer:

job market prevent a return to work with the employer and the employee would earn significantly less with a new employer without training. You are responsible for monitoring the interested parties and acting to correct breaches in good faith.

PROCEDURES:

In addition to your justification for a status change, other supporting information should be included at various points in the process. This information includes updated medical reports, psychological tests and vocational evaluations, written job offers, and training reports. You must wait for my written approval before providing services for placement with a new employer and training. I will notify you in writing if I reject your recommendations for other goals, plans, and status changes. My approval or rejection will be provided on the Form OWCP-3, Injured Workers' Rehabilitation Status Report for all services except training, which will be authorized by the Form OWCP-16, Rehabilitation Plan and Award, if we are paying for the training. You may charge a maximum professional hourly rate of The OWCP will pay you within 45 days of receiving a proper bill. You must do the following to insure that your bill is proper:

* Complete all items on the OWCP bill format.
* Submit the original monthly bill attached to the front of the original report for that month to:

REHABILITATION PAYMENT ADDRESS
U. S. Department of Labor - OWCP

* Submit a copy of the monthly bill attached to the front of a copy of the report for that month to my attention at:

U. S. DEPARTMENT OF LABOR - OWCP
ATTN: REHABILITATION SPECIALIST

Be sure the word COPY is written on the front page of both the bill and report to avoid delays in the processing of your bill.

OWCP Form 35 Routine Referral and Award (continued)

File Number:
Employee:
Employer:

INJURED WORKER'S RESPONSIBILITY:

Injured workers are expected to act in good faith during the rehabilitation effort by:

* Seeking and accepting suitable work to continue entitlement to compensation.
* Being realistic and flexible regarding adjustments they may have to make. (Since they will be in lighter jobs, they may have to adapt to changes in hours of work, shifts, pay scale, travel required to the job or on the job, promotional prospects, social and physical work environment, and benefits.)
* Providing medical evidence of disability to OWCP if problems arise.

PREVIOUS EMPLOYER'S RESPONSIBILITY:

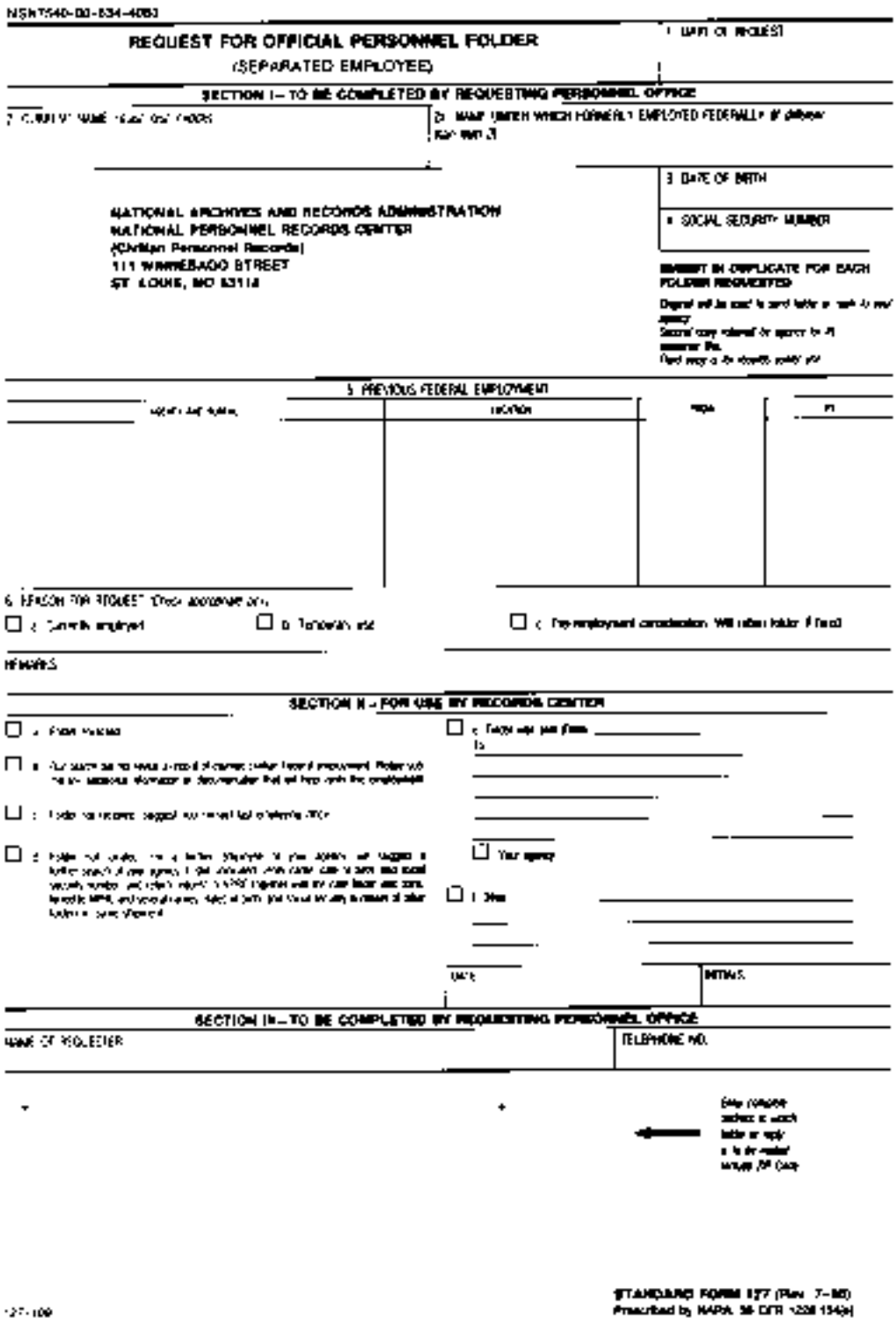
OWCP has found that rehabilitation through reemployment both reduces the cost of compensation and represents the preference of the injured worker. The employer could be benefiting from the productivity of this employee, who is receiving in compensation payments each 28 days. If employment cannot be achieved, we estimate the employer's possible compensation cost as over the lifetime of the employee.

If the employer is interested in reemployment, the job offer should be made within 90 days of receipt of medical information from you that demonstrates that the employee is ready for reemployment. The job offered must be within the employee's physical, mental, and emotional abilities Moreover, the job offer must be written and must include an official position description with specific job duties and any job accommodations made.

COUNSELOR'S RESPONSIBILITY:

You are responsible for providing an initial interview and vocational assessment to identify the employee's skills and abilities. When you determine that the employee is ready, send a letter notifying the employer that this is a reemployment referral, and include the summary of case information and current medical and work restriction information to begin the placement effort. You must have testing done when the employee is not being selectivaly placed with the employer or placed in a light-duty version of a pre-injury job. Should further medical evaluation or treatment be needed for the work-related disability, contact this office prior to initiating a program. You must either identify the case as infeasible and close it at the earliest possible time, or provide services which produce a realistic, cost-effective and timely program, consider the interests and abilities of the injured worker, and ultimately result in a return to employment. You should explore and, if feasible, develop a realistic training program if lack of transferable skills or the

Standard Form 127



NSN 7540-00-634-4093

REQUEST FOR OFFICIAL PERSONNEL FOLDER
(SEPARATED EMPLOYEE)

1 DATE OF REQUEST

SECTION I – TO BE COMPLETED BY REQUESTING PERSONNEL OFFICE

2 b NAME UNDER WHICH FORMERLY EMPLOYED FEDERALLY (If different from item 2)

3 DATE OF BIRTH

4 SOCIAL SECURITY NUMBER

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION
NATIONAL PERSONNEL RECORDS CENTER
(Civilian Personnel Records)
111 WINNEBAGO STREET
ST. LOUIS, MO 63118

SUBMIT IN DUPLICATE FOR EACH FOLDER REQUESTED

5 PREVIOUS FEDERAL EMPLOYMENT

6 REASON FOR REQUEST (Check appropriate box)

☐ a. Currently employed ☐ b. Terminated and ☐ c. Pre-employment consideration. Will return folder if hired

REMARKS

SECTION II – FOR USE BY RECORDS CENTER

☐ a. Folder not found

☐ b. Our records do not reveal a record of former civilian Federal employment. Please furnish additional information or documentation that will help locate the employment

☐ c. Folder has been charged out to requesting office

☐ d. Folder not found. Search of the agency's files identified a folder of the same or similar name. Please verify that the folder belongs to the subject identified in Section I by comparing the name, date of birth, and social security number, and other identifying data. If the folder belongs to the subject identified in Section I, please return it to the National Personnel Records Center. If the folder does not belong to the subject identified in Section I, please return it to the National Personnel Records Center with a statement to that effect.

☐ e. Folder was sent on loan from _____ to

☐ Your agency

☐ f. Other

DATE

INITIALS

SECTION III – TO BE COMPLETED BY REQUESTING PERSONNEL OFFICE

NAME OF REQUESTER

TELEPHONE NO.

Use reverse side for additional remarks

127-109

STANDARD FORM 127 (Rev. 7-85)
Prescribed by NAPA 36 CFR 1228.154(a)

Standard Form 127 (contiued)

File Number:
Employee:
Employer:

Enclosed is a summary of case information, work restriction evaluation (if applicable), and the significant medical report(s) for your official and confidential use.

Sincerely,

REHABILITATION SPECIALIST

Enclosures

Standard Form 2809

Standard Form 2809
Rev. Aug. (P 1995)

Form Approved:
OMB No. 3206-0160

Health Benefits Registration Form

Uses for Standard Form (SF) 2809

Use this form to:

- Enroll in the FEHB Program; or
- Elect not to enroll in the FEHB Program (employees only); or
- Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the Table on page 6; or
- Change your FEHB enrollment from Self and Family to Self Only; or
- Cancel your FEHB enrollment.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.
2. Annuitants (other than CSRS-FERS annuitants) eligible to enroll in or currently enrolled in the FEHB Program, including individuals receiving monthly compensation from the Office of Workers' Compensation Programs.

Note: CSRS-FERS annuitants. Do not use this form. To obtain the correct election form, write to:

Office of Personnel Management
Insurance Services Branch
P.O. Box 14712
Washington, D.C. 20044

3. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
4. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:
   - Former employees (who separate from service
   - Children who lose FEHB coverage; and
   - Former spouses who are not eligible for FEHB under item 3 above.

Note: Former spouses and children of CSRS-FERS annuitants. Do not use this form. To obtain the appropriate form, write to address shown in item 2 above.

Instructions for Completing SF 2809

Type or Print Firmly.

PART A You must complete this part.

Item 1. Give your last name, first name and middle initial.

Item 2. Enter your Social Security Number. (See Privacy Act Statement on Page 5.)

Item 3. Give your date of birth, using numbers to show the month, day and year.

Item 4. Enter your permanent home mailing address.

Item 5. Place an "X" in the appropriate box.

Item 6. Place an "X" in the box that signifies your current marital status. (If you are separated but not divorced, you are still married.)

Item 7. Give your telephone number where you can be reached during normal business hours. Be sure to include area code.

PART B Complete this part to enroll or change your enrollment in the FEHB Program. (If you are changing your enrollment, also complete PART C.)

Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to enroll in or change to. (The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.) If you are just changing from one option to another under item 1 (Self Only to Self and Family or from Self and Family to Self Only), enter the name of your present plan and the new enrollment code.

If the plan you want is a postal plan (CMP-HMO), be sure you have the plan's enrollment code. If it is an employee organization plan, be sure you are eligible to enroll in the plan; you must be or become a member of the plan's sponsoring organization.

Your signature in Part E authorizes deductions from your salary, annuity or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Standard Form 2809 (continued)

Items 2a through 2f

Complete these items only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 2a Indicate the first name and middle initial of each covered family member.

Item 2b Provide the ZIP code if it is different from the entire ZIP code in Part A, Item 4.

Item 2c Give your dependent's date of birth using numbers to show the month, day and year (e.g., 05 29 91).

Item 2d. Indicate M for male or F for female.

Item 2e Provide the code which indicates the relationship of the eligible family member to you.

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)
3. Stepchild, foster child or recognized child
4. Unmarried disabled child over age 22 incapable of self support

Item 2f Please provide Social Security Numbers for your dependents if available. If not available, explain. Numbers will not be withheld. (See Privacy Act Statement on page 5.)

Family Members Eligible for Coverage

- Unless you are a former spouse, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legal or adopted children and recognized children born out of wedlock, stepchildren or foster children who live with you in a regular parent-child relationship. A recognized child born out of wedlock also must be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

  Other relatives (e.g., your parents) are not eligible for coverage even though they live with you and are dependent upon you.

- If you are a former spouse, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent children or adopted children under age 22 of both you and your former spouse.

- Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

- In some cases, an unmarried disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you have adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self support.

  Note: Your retirement office (see Note under *General Information* on page 2) can give you additional details about family member eligibility, including the documentation required for coverage of a disabled child age 22 or older.

Item 3a Place an "X" in the appropriate box if you completed Item 1 of this part. If you answered "Yes," complete Items 3b through 3d.

Item 3b Indicate any additional insurance coverage for you or your dependents. Provide what part(s) of Medicare coverage are held. Indicate "A" if you have Part A, Medicare Hospital Insurance; and/or indicate "B" if you have Part B, Medicare Supplementary Medical Insurance. Indicate "A and B" if you have both.

PART C. You must complete this part if you are changing your enrollment.

Item 1 Enter the name of the plan in which you are presently enrolled.

Item 2 Enter your present enrollment code.

Item 3 Enter the number of the event that permits your change from the Table on page 5. (Leave this part blank if you are changing from Self and Family to Self Only.)

Item 4 Using numbers, enter the date of the event that permits your change. For Open Season changes, enter the date on which the Open Season begins. (Leave this item blank if you are changing from Self and Family to Self Only.)

PART D. Place an "X" in the box provided only if you are an employee who does not wish to enroll in the FEHB Program. (Be sure to read the information about electing not to enroll on page 4.)

PART E. Place an "X" in the box provided if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. (Be sure to read the information about cancelling your enrollment on page 4.)

PART F. You must complete this part.

Item 1 Sign your name. Do not print.

Item 2 Enter the date you sign, using numbers to show the month, day and year.

Leave *PART G and REMARKS* section blank. They are for agency use only.

If You are Registering for Someone Else

If you are registering for an employee or annuitant, under a written authorization from him or her to do so, sign your name in Part F and attach the written authorization.

Standard Form 2809 (continued)

If you are registering for a former spouse eligible for coverage under Spouse Equity or for an individual eligible for temporary continuation of coverage or his or her court-appointed guardian, sign your name in Part F and attach evidence of your court-appointed guardianship.

General Information

The following materials about the FEHB Program will be furnished to you by or may be obtained from your employing office (see **Note** below):

FEHB plan brochures, which contain detailed information about plan benefits and the contractual description of coverage.

Employees

FEHB Program Information for Federal Civilian Employees and U.S. Postal Service Employees (SF 2809-A), which explains your rights and obligations under the Program.

FE-B Enrollment Information Guide and Plan Comparison Chart, which contains enrollment plan and rate information as follows:

RI 70-1	Federal Employees (Non-Postal)
RI 70-2	Postal Employees
RI 70-7	Employees in Positions Outside the Continental U.S. including Alaska, Hawaii, Guam and Puerto Rico)
RI 70-8	Temporary Employees Eligible for FEHB Under 5 U.S.C. 8906a
RI 70-10	Visually Impaired Employees

Annuitants

FFHB Enrollment Information Guide and Plan Comparison Chart which contains enrollment, plan and rate information for

Annuitants in retirement systems other than OSRS/FERS (RI 70-4)

Individuals receiving compensation from the Office of Workers' Compensation Programs (RI 70-6)

Former Spouses (Spouse Equity)

FEHB Enrollment Information Guide and Plan Comparison Chart which contains enrollment, plan and rate information for former spouses (RI 70-5)

Individuals Eligible for Temporary Continuation of Coverage

FEHB Enrollment Information Guide and Plan Comparison Chart, which contains enrollment, plan and rate information for former employees, children and former spouses eligible for temporary continuation of coverage (RI 70-5)

Note. "Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, an annuitant, a former spouse eligible for coverage under Spouse Equity or an individual eligible for temporary continuation of coverage.

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

Temporary Continuation of Coverage (TCC)

While the employing office notifies a former employee of his or her eligibility for temporary continuation of coverage, the employing office must be notified when a child or former spouse becomes eligible.

- For the eligible child of an enrollee, the enrollee must notify the employing office within 60 days after the qualifying event occurs, e.g., child reaches age 22.
- For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within 60 days after the former spouse's change in status, e.g., the date of the divorce or former spouse's remarriage before reaching age 55.

An individual eligible for temporary continuation of coverage who wants to continue FEHB coverage may choose any plan (but not a "high option") option and type of enrollment. The time limits for a former employee, child or former spouse to file the SF 2809 with the employing office appear in Events No. 24, 25 and 26 in the Table on page 6.

Note. *If someone other than the enrollee notifies the employing office of the child's eligibility for temporary continuation of coverage within the specified time period, the child's opportunity to file the SF 2809 ends 60 days after the qualifying event. If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to file the SF 2809 ends 60 days after the change in status.*

Effective Dates

Your employing office can give you the specific date on which your enrollment or enrollment change will take effect. Additional information about effective dates appears in the Table on page 6.

Standard Form 2809 (continued)

Note 1: If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.

Note 2: If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.

Cancellation of Enrollment

You may cancel your enrollment at any time. However, if you cancel, neither you nor any family member covered by your enrollment will be entitled to a 31-day extension of coverage for conversion to nongroup coverage. Moreover, family members who lose coverage because of your cancellation will not be eligible for temporary continuation of coverage. (Be sure to read the additional information below about cancelling your enrollment.)

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire

- Under a retirement system for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for

- The five years of service immediately before retirement (i.e., commencing date of annuity entitlement), or
- If fewer than five years of service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment (in your Federal career) to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the Table on page 6. Some employees delay their enrollment or reenrollment until they qualify for FEHB coverage as a retiree. However, there is always the risk that they will have to retire earlier than expected (e.g., due to disability or involuntary separation) and not be able to meet the five-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment you are **voluntarily accepting this risk.** An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note: Temporary employees eligible for FEHB under 5 U.S.C. 8906 — Your decision not to enroll or to cancel your enrollment will not affect your future eligibility to continue FEHB enrollment after retirement.

Annuitants Who Cancel Their Enrollment

You cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. See the Table on page 6 for events that allow eligible annuitants to reenroll.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

If you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under spouse equity continues. You may reenroll as a former spouse when the other FEHB coverage ends.

If you cancel a family enrollment, the covered children may be eligible for continued coverage if the children are receiving a survivor annuity based on the service of the other parent and the other parent had family coverage at the time of death. In this circumstance, you should contact the other parent's retirement system promptly to have the children enrolled as survivor annuitants. The children must enroll for FEHB coverage as survivor annuitants within 31 days after your cancellation.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees).

Note 2: Former spouses (spouse equity) and temporary continuation of coverage enrollees who fail to pay their premiums within specified time frames are considered to have voluntarily cancelled their enrollment.

Standard Form 2809 (continued)

Privacy Act Statement

The information you provide on this form is needed to document in your records the maintained by your employing office your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs. In addition, to the extent this information indicates possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

We also request that you provide your Social Security Number so that it may be used as your individual identifier in the Federal Employees Health Benefits Program. Executive Order 9397, dated November 22, 1943, allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records systems in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Management and Budget, Paperwork Reduction Project (3206-0160), Washington D.C. 20503.

Standard Form 2809 (continued)

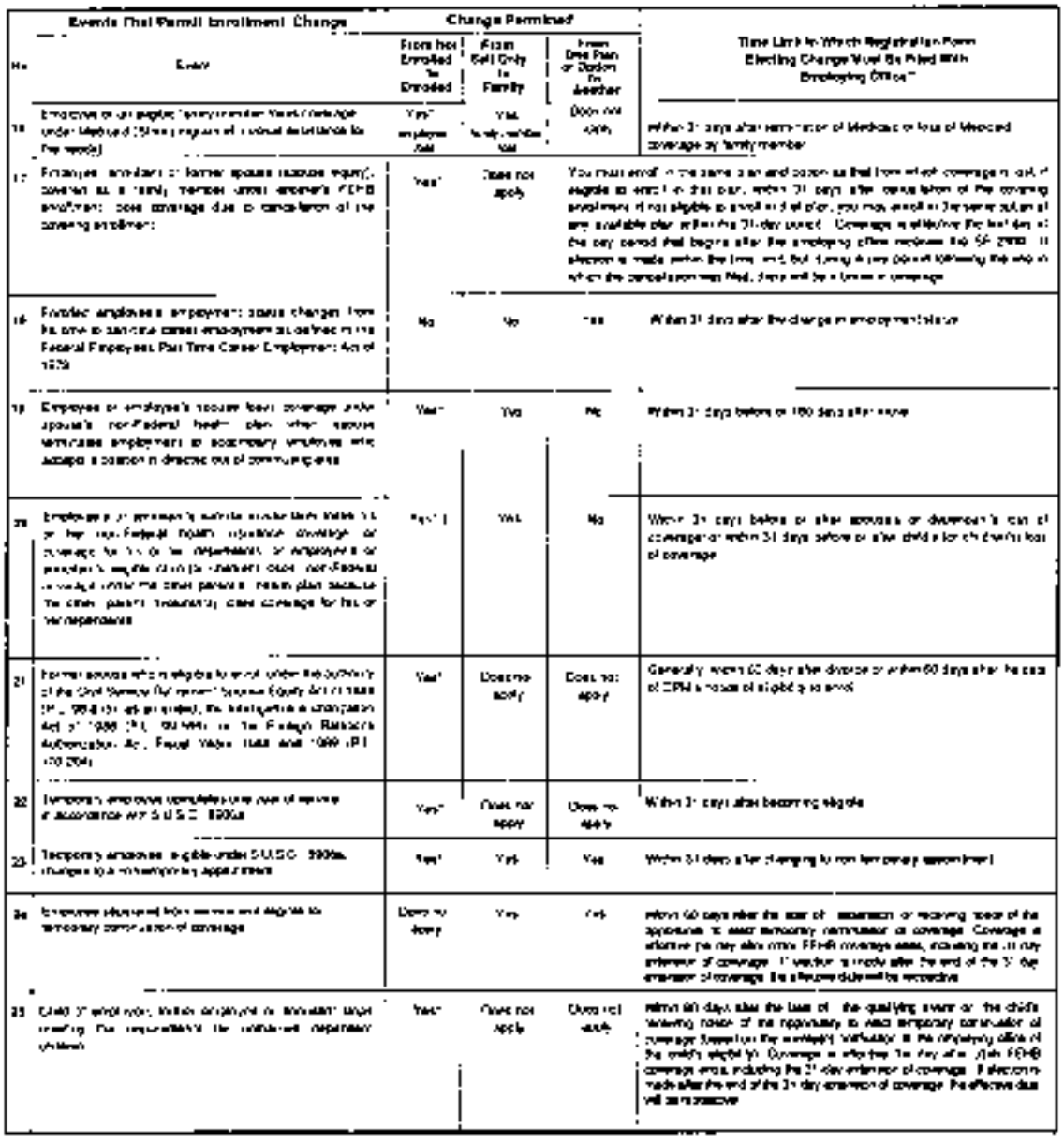
TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT
Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time

No.	Events That Permit Enrollment Change Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
1	Open Season	Yes*†	Yes	Yes	As announced by the Office of Personnel Management
2	Change in residence or [illegible] divorce annulment death of spouse)	Yes*†	Yes (Except former spouse)	Yes (Except former spouse)	From 31 days before to 60 days after change in marital status
3	Other changes in family status (For example, birth of a child, legal separation, discharge from military service of a spouse or a child under age 22)	No	Yes	No	Within 60 days after change in family status.
4	Enrollee or family member moves from an area served by a prepaid plan (CNDP/HMO) in which enrolled at time of move.	Does not apply	Yes	Yes	At any time while presenting written notice to the employing office of the move
5	Termination of enrollment by employee organization plan because of termination of membership in employee [illegible]	Does not apply	No	Yes	Within 31 days after termination of enrollment option
6	Employee, annuitant or former spouse (spouse thereby) covered as a family member under another's FEHB enrollment, loses coverage other than by cancellation or change to Self Only of the covering enrollment, or employee covered under another federally sponsored health benefits program, loses such coverage for any reason	Yes*	Does not apply	Does not apply	Within 31 days after termination (except for employee, within 60 days after the cause of the action). Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.
7	Employee, annuitant or former spouse (spouse only) covered as a family member under another's FEHB enrollment, loses coverage because of change of the covering enrollment to Family to Self Only	Yes for Self Only	Does not apply	Does not apply	Within 31 days after change of covering enrollment has been met. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.
8	Employee transfers overseas post of duty from the United States, or reverse	Yes*	Yes	Yes	Within 31 days before or after move
9	Employee returns to active civilian duty or annuitant separates from military service which was not limited to 30 days or less	Yes*†	Yes	Yes	Within 31 days after return to active civilian duty or separation from military service
10	Your pay unit participating in the FEHB Program	Does not apply	Yes	Yes	As set by the Office of Personnel Management.
11	Self Only enrollment under the Program of Insurance of employee's spouse terminates as a result of change in spouse's Federal employment status or 365 days' leave status	No	Yes	No	Within 31 days after termination of spouse's enrollment. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage
12	Employee who is not enrolled loses coverage under parent's non-Federal health plan	Yes*	Does not apply	Does not apply	Within 31 days after loss of coverage, or within 60 days after the death of the parent.
13	Enrolled employee leaves from overseas post of duty and elects to continue enrollment as annuitant	Does not apply	Yes	Yes	Within 60 days after retirement
14	Enrollee becomes eligible for Medicare	Does not apply	No	Yes	At any time beginning 30 days before becoming eligible for Medicare
15	Enrollee's eligible married children lose coverage under another's FEHB enrollment	No	Yes	No	Within 31 days after child's children's loss of coverage. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.

* Individuals must be offered an opportunity to enroll
† Employees only

** Also see other effective date information.

Standard Form 2809 (continued)



No.	Event	Change Permitted: From Not Enrolled to Enrolled	Change Permitted: From Self Only to Family	Change Permitted: From One Plan or Option to Another	Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
16	Employee or an eligible family member loses Medicaid or Medicare eligibility	Yes*	Yes	Does not apply	Within 31 days after termination of Medicaid or loss of Medicaid coverage by family member
17	Employee enrolled in former spouse separate equity coverage as a family member under employee's FEHB enrollment loses coverage due to cancellation of the covering enrollment	Yes*	Does not apply	You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan. Within 31 days after cancellation of the covering enrollment if not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day period. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit but during a pay period following the pay in which the cancellation was filed, there will be a break in coverage	
18	Former employee's employment status changes from full-time to part-time career employment as defined in the Federal Employees Part-Time Career Employment Act of 1978	No	No	Yes	Within 31 days after the change in employment status
19	Employee or employee's spouse loses coverage under spouse's non-Federal health plan when spouse terminates employment or accompany employee who accepts a position in overseas or noncontiguous area	Yes*	Yes	No	Within 31 days before or 180 days after move
20	Employee or annuitant's spouse loses Medicare or other Federal health insurance coverage or coverage for him or her as dependent of employee or annuitant's eligible child (a dependent child non-Federal coverage under the child parent's health plan because the child parent involuntarily loses coverage for his or her dependents)	Yes*	Yes	No	Within 31 days before or after spouse's or dependent's loss of coverage or within 31 days before or after child's or child parent's loss of coverage
21	Former spouse who is eligible to enroll under Title 5 (Civil Service Retirement System Spouse Equity Act of 1984 (P.L. 98-615) or as amended, the Uniformed Services Former Spouses' Protection Act (P.L. 97-252) or the Former Spouses Protection Act, Public Laws 1048 and 1089 (P.L. 101-256))	Yes*	Does not apply	Does not apply	Generally within 60 days after divorce or within 60 days after the date of OPM's notice of eligibility to enroll
22	Temporary employee completes one year of service in accordance with 5 U.S.C. 8906a	Yes*	Does not apply	Does not apply	Within 31 days after becoming eligible
23	Temporary employee eligible under 5 U.S.C. 8906a changes to a nontemporary appointment	Yes†	Yes	Yes	Within 31 days after changing to nontemporary appointment
24	Employee separated from service and eligible for temporary continuation of coverage	Does not apply	Yes	Yes	Within 60 days after the date of separation or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after prior FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be prospective
25	Child of employee, former employee or annuitant (not covering the responsible for the child) loses dependent children	Yes*	Does not Apply	Does not apply	Within 60 days after the loss of the qualifying event or the child's receiving notice of the opportunity to elect temporary continuation of coverage (except the overlight individual in the employing office of the child's eligible for). Coverage is effective the day after prior FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be prospective

* Individuals must be otherwise eligible to enroll

† Employees only

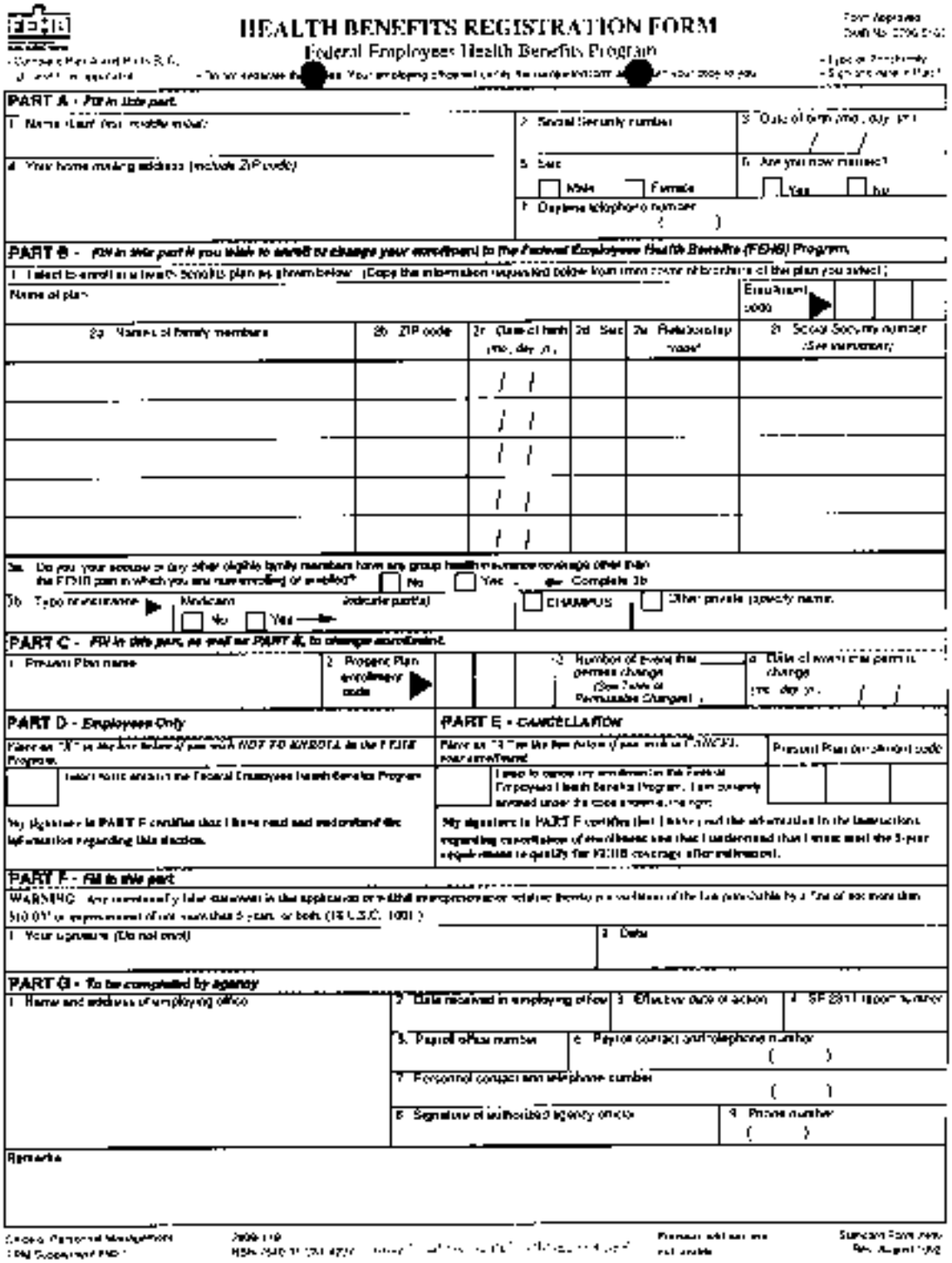
** Area selection effective date information

Standard Form 2809 (continued)

No.	Events That Permit Enrollment Changes Event	Change Permitted From Not Enrolled to Enrolled	From Self Only to Family	From One Plan to Option in Another	Time Limit in Which Registration Form Reporting Change Must Be Filed with Employing Office**
8d	Former spouse loses [illegible] coverage under 5 CFR Part 890 Subpart L because of having been enrolled in FEHB (self only) [illegible] member at some time during the 18 months before the marriage ended but does not have one or both of the other two opportunities in 5 U.S.C. 8905(b)	Yes*	Does not apply	Does not apply	Within 60 days after the date of the qualifying event the date coverage under Subpart L of 5 CFR Part 890 was lost, whichever is later. In the case of the qualifying event, or the former spouse's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's or former spouse's notification to the employing office of the former spouse's eligibility). Coverage is effective the day after the FEHB coverage ends, including the 31 day extension of coverage, or the date of the qualifying event, if later. If election is made after the end of the 31-day extension of coverage or the date of the qualifying event, the effective date will be retroactive.
9f	Former employee, former spouse, or child whose temporary continuation of coverage under 5 CFR Part 890 Subpart L or conversion has ended other FEHB coverage (other than the same FEHB coverage)	Yes*	Does not apply		You must transfer to the same plan and option as that in which you were enrolled prior to obtaining the other FEHB coverage, if eligible to enroll in that plan, within 31 days after the other coverage ends, but not later than the expiration of the period of eligibility for the temporary continuation of coverage. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day time limit.

* Individual must be determined eligible to enroll.
† Employees only.
** An earlier effective date may be [illegible]

Standard Form 2809 (continued)



HEALTH BENEFITS REGISTRATION FORM
Federal Employees Health Benefits Program

PART A - Fill in this part.

1 Name (Last, first, middle initial)
2 Social Security number
3 Date of birth (mo., day, yr.)
4 Your home mailing address (include ZIP code)
5 Sex: Male Female
6 Are you now married? Yes No
7 Daytime telephone number ( )

PART B - Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.

1 I elect to enroll in or change to a FEHB plan as shown below. (Copy the information requested below from your most recent statement of the plan you select.)
Name of plan
Enrollment code

2a Names of family members	2b ZIP code	2c Date of birth (mo., day, yr.)	2d Sex	2e Relationship (spouse, child)	2f Social Security number (See instructions)
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

3a Do you, your spouse, or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No Yes - go to Complete 3b
3b Type of insurance: Medicare (indicate parts) No Yes — go to CHAMPUS Other private (specify name)

PART C - Fill in this part, as well as PART B, to change enrollment.

1 Present Plan name
2 Present Plan enrollment code
3 Number of events that permit change (See Table of Permissible Changes)
4 Date of event that permits change (mo., day, yr.)

PART D - Employees Only

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.
I elect not to enroll in the Federal Employees Health Benefits Program.
My signature in PART F certifies that I have read and understand the information regarding this election.

PART E - CANCELLATION

Place an "X" in the box below if you wish to CANCEL your enrollment.
Present Plan enrollment code
I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown at the right.
My signature in PART F certifies that I have read the information in the instructions regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

PART F - Fill in this part

WARNING: Any intentionally false statement in the application or willful misrepresentation violates [illegible] punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1 Your signature (Do not print)
2 Date

PART G - To be completed by agency

1 Name and address of employing office
2 Date received in employing office
3 Effective date of action
4 SF 2811 report number
5 Payroll office number
6 Payroll contact point/telephone number ( )
7 Personnel contact point/telephone number ( )
8 Signature of authorized agency official
9 Phone number ( )

Remarks

Standard Form 2810

FEHB

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1 Name (Last, first, middle initial)	2 Date of birth	3 Social Security Number
4 Address (including ZIP Code)	5 Payroll Office Number	6 Enrollment Code Number
	7 SF 2809 Agency No.	8 Date new service becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is temporarily extended for 31 days after that date.

Important Notice: You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage. See Part B - Termination on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

Part C - Transfer Out

☐ This enrollment continues but is transferred to the new Payroll Office or Retirement System shown below. See Part C on the back of this form for more information.

Part D - Transfer In

☐ The new Payroll Office or Retirement System shown in Part I below has accepted transfer of this enrollment and will continue it.

Part E - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part F - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to

Name | Date of birth

Address (including ZIP Code) if different from Part A, item 4, above

Part G - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below.

(Note: This item is completed by Retirement Systems only.)

New Enrollment Code Number →

Part H - Remarks

Part I - Date of Notice

(Note: Instructions for Employing Offices are on the back of Copy 4 of this form.)

Name and address of agency (including ZIP Code)

Signature of authorized agency official | Date

U.S. Office of Personnel Management
FPM Supplement 890-1
NSN 7540-01-352-1251 9515-107

Copy 1 - To Enrollee

Standard Form 2810
Revised January 1990
Prescribed by GSA/FPMR (41 CFR) 101-11.6

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