Explanation of Form CA-1

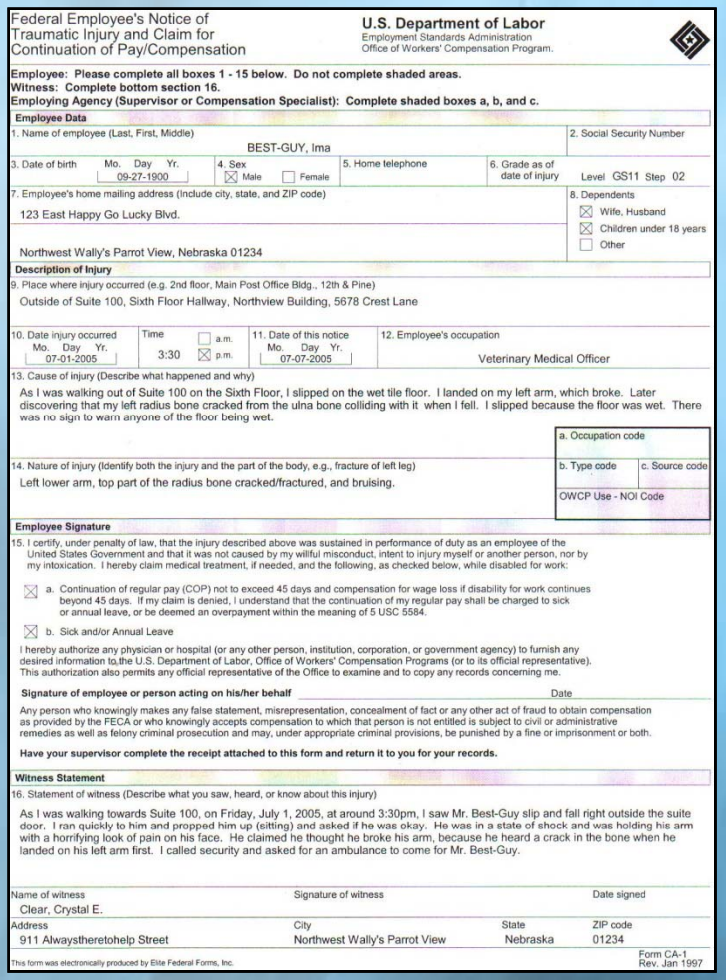
IMPORTANT

You must click your mouse, press Enter, or use your arrow keys on your keyboard to move throughout this slide show.

Form CA-1

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

- The Form CA-1 was developed to ensure regulatory compliance and to be more customer friendly. The form must be completed by the injured employee, a witness, and the injured employee's supervisor.



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 Program.

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): BEST-GUY, Ima
2. Social Security Number:
3. Date of birth (Mo. Day Yr.): 09-27-1900
4. Sex: ☒ Male ☐ Female
5. Home telephone:
6. Grade as of date of injury: Level GS11 Step 02
7. Employee's home mailing address (Include city, state, and ZIP code): 123 East Happy Go Lucky Blvd. Northwest Wally's Parrot View, Nebraska 01234
8. Dependents: ☒ Wife, Husband ☒ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Outside of Suite 100, Sixth Floor Hallway, Northview Building, 5678 Crest Lane
10. Date injury occurred (Mo. Day Yr.): 07-01-2005 Time: 3:30 ☐ a.m. ☒ p.m.
11. Date of this notice (Mo. Day Yr.): 07-07-2005
12. Employee's occupation: Veterinary Medical Officer
13. Cause of injury (Describe what happened and why): As I was walking out of Suite 100 on the Sixth Floor, I slipped on the wet tile floor. I landed on my left arm, which broke. Later discovering that my left radius bone cracked from the ulna bone colliding with it when I fell. I slipped because the floor was wet. There was no sign to warn anyone of the floor being wet.
14. Nature of injury (Identify both the injury and the part of the body, e.g., fracture of left leg): Left lower arm, top part of the radius bone cracked/fractured, and bruising.

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

Employee Signature

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

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

☒ b. Sick and/or Annual Leave

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

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

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

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

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury): As I was walking towards Suite 100, on Friday, July 1, 2005, at around 3:30pm, I saw Mr. Best-Guy slip and fall right outside the suite door. I ran quickly to him and propped him up (sitting) and asked if he was okay. He was in a state of shock and was holding his arm with a horrifying look of pain on his face. He claimed he thought he broke his arm, because he heard a crack in the bone when he landed on his left arm first. I called security and asked for an ambulance to come for Mr. Best-Guy.

Name of witness	Signature of witness		Date signed
Clear, Crystal E.			
Address	**City**	**State**	**ZIP code**
911 Alwaystheretohelp Street	Northwest Wally's Parrot View	Nebraska	01234

This form was electronically produced by Elite Federal Forms, Inc.

Form CA-1
Rev. Jan 1997

Process of Form CA-1

Form CA-1 is available at: *http://www.dol.gov/esa/regs/compliance/owcp/ca-1.pdf*

Steps to Complete Form CA-1:

- (1) The employee, who is claiming traumatic injury and claim for continuation of pay/compensation, must complete all boxes 1-15, including signature.
- (2) The witness must then complete box 16, including signature.
- (3) The supervisor must complete the Supervisor's Report, 17-38, including signature. They must also complete the Privacy Act Section on page 3.
- (4) Page 2, box 39, supervisor must check the appropriate filing instructions box.

Where there is a box to indicate a choice, simply click on the appropriate box to make your selection

Enter ALL Identifying information in the appropriate boxes

13) Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Give complete description of the condition(s) resulting from your injury. specify the right or left side if applicable (e.g.: fractured left leg; cut on right index finger).

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

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

Employee: Please complete all boxes ...mplete shaded areas.
Witness: Complete bottom section 16
Employing Agency (Supervisor or Compensatio ...cialist): **Complete shaded boxes a, b, and c.**

Employee Data

1. Name of employee (Last, First, Middle)		2. Social Security Number
BEST-GUY, Ima		123-45-5678

3. Date of birth (Mo. Day Yr.)	4. Sex	5. Home telephone	6. Grade as of date of injury
09-27-1900	☒ Male ☐ Female	987-654-3210	Level GS11 Step 02

7. Employee's home mailing address (Include city, state, and ZIP code)
123 East Happy Go Lucky Blvd.
Northwest Wally's Parrot View, Nebraska 01234

8. Dependents
☒ Wife, Husband
☒ Children under 18 years
☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
Outside of Suite 100, Sixth Floor Hallway, Northview Building, 5678 Crest Lane

10. Date injury occurred (Mo. Day Yr.)	Time	11. Date of this notice (Mo. Day Yr.)	12. Employee's occupation
07-01-2005	☐ a.m. 3:30 ☒ p.m.	07-07-2005	Veterinary Medical Officer

13. Cause of injury (Describe what happened and why)
As I was walking out of Suite 100 on the Sixth Floor, I slipped on the wet tile floor. I landed on my left arm, which broke. Later discovering that my left radius bone cracked from the ulna bone colliding with it when I fell. I slipped because the floor was wet. There was no sign to warn anyone of the floor being wet.

14. Nature of injury (Identify both the injury and the part of the body, e.g., fracture of left leg)
Left lower arm, top part of the radius bone cracked/fractured, and bruising.

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

This section will be filled out by your worker's compensation contact. The list of contacts can be found on the last slide.

...ployee Signature

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

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

☒ b. Sick and/or Annual Leave

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

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

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

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

Employee Signature

Employee Signature

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

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

☐ b. Sick and/or Annual Leave

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

Signature of employee or person acting on his/her behalf John Doe Date 4/7/05

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

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

15) 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 convert past periods of leave to 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 change COP to sick or annual leave or pay the employing agency back for the COP received.

Witness Signature

Witness Statement

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

As I was walking towards Suite 100, on Friday, July 1, 2005, at around 3:30pm, I saw Mr. Best-Guy slip and fall right outside the suite door. I ran quickly to him and propped him up (sitting) and asked if he was okay. He was in a state of shock and was holding his arm with a horrifying look of pain on his face. He claimed he thought he broke his arm, because he heard a crack in the bone when he landed on his left arm first. I called security and asked for an ambulance to come for Mr. Best-Guy.

Crystal E. Clear — Signature of witness

7-7-05 — Date signed

Name of witness: Clear, Crystal E.

Address	City	State	ZIP code
911 Alwaystheretohelp Street	Northwest Wally's Parrot View	Nebraska	01234

This form was electronically produced by Elite Federal Forms, Inc.

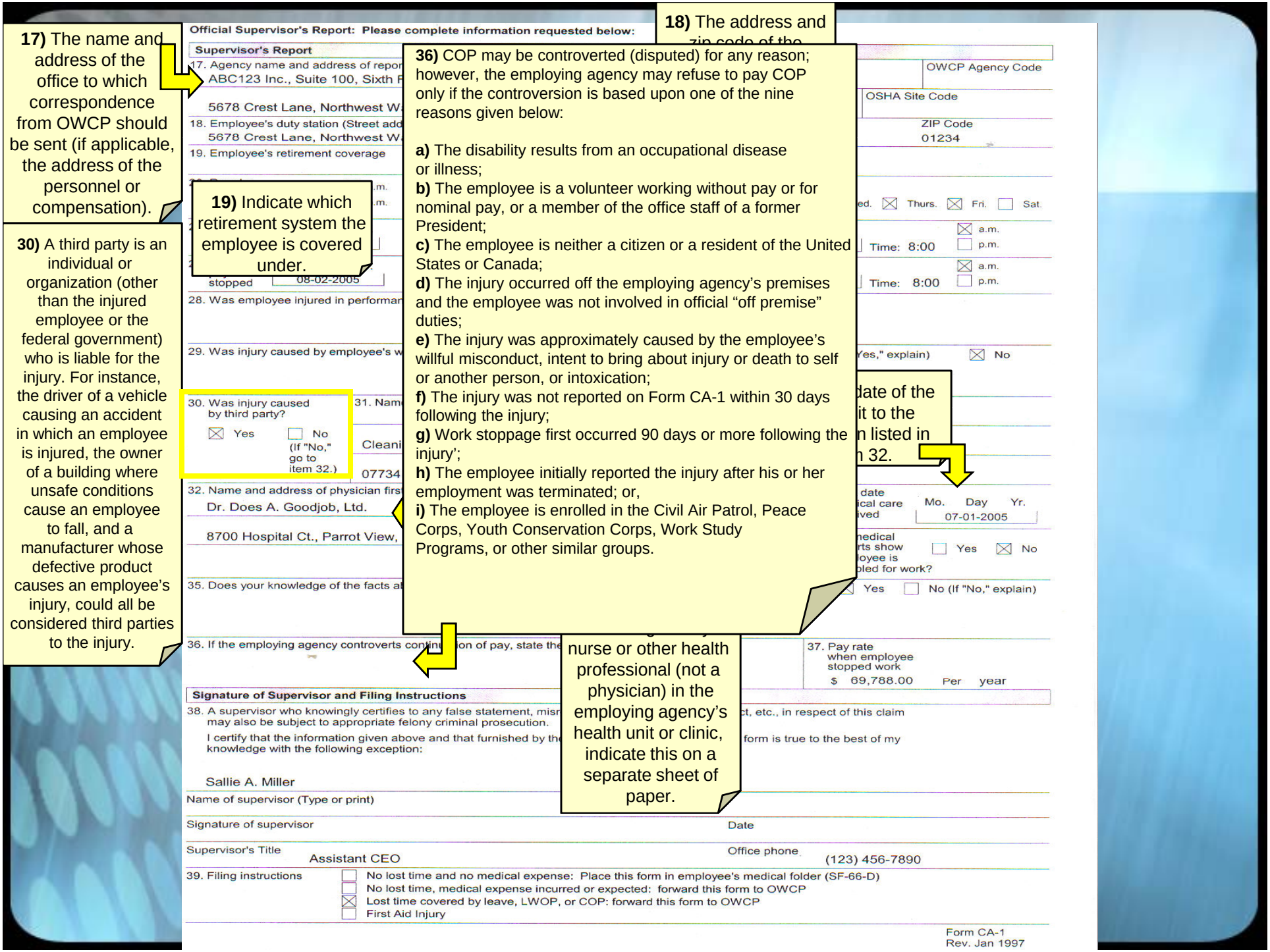
Form CA-1
Rev. Jan 1997

Supervisor

At the time of the form is received, complete the receipt of notice 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 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to Worker's Compensation contact within 3 working days after it is received.

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

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.


17) The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation).
18) The address and zip code of the
19) Indicate which retirement system the employee is covered under.
30) 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.
36) 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 office staff of a former President;
c) The employee is neither a citizen or a resident of the United States or Canada;
d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
e) The injury was approximately 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 90 days or more following the injury';
h) The employee initially reported the injury after his or her employment was terminated; or,
i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.
nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.
Official Supervisor's Report: Please complete information requested below:
Supervisor's Report
17. Agency name and address of repor
ABC123 Inc., Suite 100, Sixth F
5678 Crest Lane, Northwest W
18. Employee's duty station (Street add
5678 Crest Lane, Northwest W
19. Employee's retirement coverage
OWCP Agency Code
OSHA Site Code
ZIP Code
01234
ed. Thurs. Fri. Sat.
Time: 8:00 a.m. p.m.
Time: 8:00 a.m. p.m.
stopped 08-02-2005
28. Was employee injured in performar
29. Was injury caused by employee's w
Yes," explain) No
30. Was injury caused by third party? Yes No (If "No," go to item 32.)
31. Nam
Cleani
07734
32. Name and address of physician firs
Dr. Does A. Goodjob, Ltd.
8700 Hospital Ct., Parrot View,
date of the it to the n listed in n 32.
date ical care ived Mo. Day Yr. 07-01-2005
nedical rts show oyee is bled for work? Yes No
35. Does your knowledge of the facts a
Yes No (If "No," explain)
36. If the employing agency controverts contin on of pay, state the
37. Pay rate when employee stopped work $ 69,788.00 Per year
Signature of Supervisor and Filing Instructions
38. A supervisor who knowingly certifies to any false statement, misr may also be subject to appropriate felony criminal prosecution.
ct, etc., in respect of this claim
I certify that the information given above and that furnished by th knowledge with the following exception:
form is true to the best of my
Sallie A. Miller
Name of supervisor (Type or print)
Signature of supervisor
Date
Supervisor's Title Assistant CEO
Office phone (123) 456-7890
39. Filing instructions
No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
No lost time, medical expense incurred or expected: forward this form to OWCP
Lost time covered by leave, LWOP, or COP: forward this form to OWCP
First Aid Injury
Form CA-1
Rev. Jan 1997

Supervisor's Signature

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Sallie A. Miller

Name of supervisor (Type or print)

Signature of supervisor Sallie Miller Date 7/8/05

Supervisor's Title Assistant CEO Office phone (123) 456-7890

39. Filing instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☒ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Form CA-1
Rev. Jan 1997

Privacy Act

Supervisor's Signature

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers'

At the time an employee stops work following a traumatic,

disability extends beyond such period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as

If disability exceeds, or it 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

Receipt of Notice of Injury

This acknowledge receipt of Notice of Injury sustained by
(Name of injured employee)

Im a Best-Guy

Which occurred on (Mo., Day, Yr.)

July 1, 2005

At (Location)

Suite 100, 6th Fl. Northview Bldg. 5678 Crest Lane

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
Sassie Witter	Assistant CEO	7/8/05

Form CA-1
Rev. Jan 1997

Receipt of Notice of Injury

Supervisor will give this receipt to the injured employee.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processnig and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledge receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior	Title	Date (Mo., Day, Yr.)

Form CA-1
Rev. Jan 1997

Worker's Compensation Contact List

Click on the button to view the list of Worker's Compensation Contacts

QUESTIONS?

If you have any questions on completing this form, please contact:

Denise Coleman

OWCP Program Manager

301-734-8350

or

Marquess Commodore

Worker's Compensation Specialist

301-734-8133

Safety, Health, and Employee Wellness Branch