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DEPARTMENT OF MILITARY AFFAIRS
SANTA FE, NEW MEXICO 87502-4277

AGONM TECHNICIAN PERSONNEL
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TECHNICIAN PERSONNEL (ARMY & AIR)
ON-THE-JOB INJURIES AND DISABILITIES

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CHAPTER 1

GENERAL

1-1 INTRODUCTION

a. The Federal Employees Compensation Act (FECA), as administered by the Office of Worker's Compensation Programs (OWCP), provides compensation and medical care for all Federal civil service employees (Both Temporary & Permanent) of the New Mexico National Guard for disability due to personal injury sustained while in the performance of duty. The law also provides for the payment of funeral and burial expenses and compensation for dependents if the injury or disease causes the technician's death. The law applies equally to temporary and permanent technicians while serving as Federal petit or grand jurors or as volunteer civilian members of the Civil Air Patrol.

(1) FECA covers a technician at any hour, day or place as long as he is officially working, participating in an approved physical training program, or traveling in a technician status.

(2) Injuries received while performing National Guard MUTAs, UTAs, Annual Training or any other types of active duty are not covered by this directive.

(3) On-the-job injury claims cannot be paid by the employee's medical insurance under the Federal Employees' Health Benefit Act.

b. This regulation is published to aid technicians and supervisors in filing claims for on-the-job injuries and occupational illnesses or diseases. Final determinations regarding claims must be made solely by the Department of Labor, Office of Worker's Compensation.

1-2 COVERAGE. The provisions of this guide will apply to all Army and Air National Guard excepted and competitive technicians.

1-3 DEFINITIONS. As used in this and subsequent sections, the following definitions will apply.

a. Assigned duties are those duties authorized to be performed in connection with a given job or jobs. Incidental duties directly connected with the performance of a given job are also considered assigned duties. Technicians who are in a State active duty status are not considered to be performing assigned duties in a technician status and are not covered under the Federal Employees Compensation Act.

- b. CA, is a symbol followed by a number which identifies Office of Workers Compensation forms. These forms are used for the purpose of reporting injuries or diseases contracted in the performance of duty and for authorizing medical care and/or treatment for job-related injuries and diseases. Para 4-2 contains a list of CA forms.
- c. Continuation of pay is the period of time during which (not to exceed 45 calendar days) a technician's regular pay may be continued without charge to leave while he/she is absent from work as a result of a job-related traumatic injury.
- d. Controvert as used in this publication means to contend against or to dispute a claim.
- e. Dependents include a wife or husband; a solely dependent parent; a child either under 18 years of age or, if over 18, incapable of self support or a student under 23 years of age who has not completed 4 years of education beyond the high school level.
- f. Injury includes, in addition to any bodily injury by accident, a disease or illness caused by the performance of assigned duties.
- g. Monthly pay means the technician's monthly pay at the time of injury or the monthly pay at the time disability begins.
- h. Occupational illnesses or diseases are defined as illnesses that are produced by systemic infections, continued or repeated stress or strain, exposure to toxins, poisons, fumes, etc., or other continued and repeated exposure to conditions of the work environment over a long period of time. Form CA-2 is used for reporting an occupational illness or disease.
- i. Supervisor is the technician immediately responsible for scheduling the work of subordinate technicians and for guiding them in their work performance.
- j. Third party means persons or agencies other than the National Guard or the Federal Government who may be liable for the injury or death of a technician.
- k. Traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain, including damage or destruction to prosthetic devices or appliances, exclusive of eyeglasses and hearing aids; unless the eyeglasses and hearing aids were damaged incidental to an on-the-job injury requiring medical services. A traumatic injury must be identifiable as to time and place of occurrence and the name or function of the body part affected. It must be caused by a specific event or series of events or incidents within a single day or work shift. Form CA-1 is used for reporting of traumatic injuries.
- l. Widow or widower is the spouse living with or dependent upon the technician for support at the time of his/her death, or living apart for reasonable cause.

m. US Medical Officer or Hospital. The Term US Medical Officer or hospital includes medical offices and hospitals of the Army, Navy, Air Force, Veterans Administration and the US Public Health Service. See Annex A for approved facilities which can be used by the New Mexico Army/Air National Guard technicians.

n. Physician. The term physician includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists and chiropractors. Chiropractors are included 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-rays to exist and are subject to regulation by the Secretary of Labor. Any change in physician must be approved by OWCP.

1-4 EXCLUSIVENESS OF REMEDY. A technician who is injured while in the performance of duty has no right to recover damages from the United States for the effects of the injury except as provided through the Federal Employees Compensation Act. The benefits provided by the act constitute the exclusive remedy for a work-related injury, illness, or death.

CHAPTER 2

BENEFITS

2-1 ENTITLEMENTS. When a technician is killed or injured or contracts a disease as a result of the performance of assigned duties, the technician or surviving dependents become eligible for certain benefits provided that such injury, illness, or death was not caused by or the result of the technician's willful conduct, the technician's intent to bring about the injury or death of himself or another person, or the technician's intoxication. Benefits available to eligible technicians covered by the Federal Employees Compensation Act are indicated in the following paragraphs.

2-2 MEDICAL CARE. Complete medical and hospital care necessary for the treatment of a job-related injury are provided. Medical care may be provided by a duly qualified local private physician or hospital of the technician's choice. Such care is contingent upon the receipt of proper authorization for medical treatment and the submission of the required reports and records to the appropriate Office of Worker's Compensation Program's district office of the Department of Labor with responsibility for adjudicating the claim. When travel is necessary to receive medical care, the injured technician may be furnished transportation or may be reimbursed for travel and incidental expenses. Medical care does not cease after termination of employment. U.S. Medical Officers and hospitals may also be used if available (see Annex A).

2-3 CONTINUATION OF PAY - TRAUMATIC INJURY. A technician who sustains a job-related traumatic injury in the performance of assigned duties is entitled to continuation of regular pay without charge to leave for a period of not more than 45 days. This pay is subject to income tax, retirement and other deductions. The technician must indicate when completing the Form CA-1 whether he/she elects to be carried in a continuation of pay status or annual/sick leave status. The 45 days are interpreted as calendar days. If the technician has stopped working due to the disabling effect of the injury, the 45 days start at the beginning of the first shift after day of injury. The technician will be kept in a pay status for any fraction of a day or shift on which the disability begins without charge to the 45 day period. If the technician is not immediately disabled as a result of the injury, the 45 days begin on the first full day or first full shift on which disability begins. In the event a technician suffers a recurrence of a disability, and the initial claim had been approved by OWCP, the technician may elect to use the balance of the 45 days that were not used during the initial period of disability. In cases of recurrence, the use of the balance of the 45-day period is permissible only if the recurrence occurred within the 90-day period beginning from the date the technician returned to work from the initial period of injury. If recurrence happens after the 90 days have elapsed, the technician is only eligible for compensation payments from OWCP, regardless of the number of unused days remaining the 45-day period. Continuation of pay is not considered compensation; however, any other benefits (such as medical care) are considered compensation. In computing a technician's pay for compensation cases, the Department of Labor, Bureau of Employee's Compensation has ruled that all active duty pay received during the one-year period prior to the date of injury, regardless of whether active duty was performed under

call or under an order, be included in determining the pay rate for compensation purpose (e.g., all inactive duty training assemblies, service schools and additional flying training periods). A day or portion of a day spent by an injured employee in a light duty job within the first 45 days of disability following an injury should be counted as a day of COP.

2-4 CHARGING CONTINUATION OF PAY (COP) FOR LIGHT DUTY ASSIGNMENT IN CASES OF COMPENSABLE TRAUMATIC INJURY

The U.S. Department of Labor establishes that Continuation of Pay (COP) as provided under the Federal Employees' Compensation Act (FECA) at 5 USC 8118 is to be charged when an employee works in a light duty assignment due to work limitations imposed by the injury.

OWCP has determined that COP is chargeable only when there has been a formal assignment to an established job which is normally paid at a lower salary and would otherwise result in loss of income to the employee. COP must be charged against the employee's 45-day entitlement when, due to the effects of the injury upon the employee:

- a personnel action has been taken to assign or detail the employee to an identified position for which a position description exists which is classified at a lower salary level than that earned by the employee when injured; or
- a personnel action has been taken to change the employee to a lower grade, or to a lower rate of basic pay; or
- a personnel action has been taken to change the employee to a different schedule of work which results in loss of salary or premium pay (e.g., Sunday pay or night differential) authorized for the employee's normal administrative workweek.

The employee must be furnished with documentation of the personnel action prior to the effective date of the action.

Return to work on a light duty reassignment or detail is to be reported to OWCP on Form CA-3, in which the new assignment or detail is reflected at items 10 through 14 and 18 through 21. If the employee worked at a lower paying job but received the full pay for his or her normal job, the difference between the employee's pay and the pay for the light duty job will be shown at item 19 of Form CA-3 as the gross dollar amount of COP. Item 19 should be altered by the completing official to make it clear that the amount shown is the difference between the pay for the employee's normal job and the pay for the light duty job during the period reported.

For additional information and instruction on light duty, supervisors should consult Annex Q of this regulation.

2-5 CONTROVERSION. The employing agency, on the basis of information submitted by the technician or secured on investigations, is required to controvert and terminate continuation of the technician's pay if the claim falls into one or more of the categories shown in paragraph a below. In all other cases the agency may controvert but not terminate continuation of pay. In such cases the technician's regular pay will not be interrupted during the 45-day period unless the controversion is sustained by the Office of Workers Compensation Programs (OWCP). If controversion is sustained and the claim is denied, the technician may substitute sick or annual leave for the period he was carried in a continuation of pay status, or have adjustment made to his or her pay as an overpayment.

a. The employing agency will controvert and terminate pay only if:

(1) The disability is a result of an occupational disease or illness; or

(2) The injury occurred off the employing agency's premises, and the technician was not involved in official "off premise" duties; or

(3) The injury was caused by the technician's willful misconduct or the technician intended to bring about the injury or death of himself or another person, or the technician's intoxication was the cause of the injury; or

(4) The injury was not reported on Form CA-1 within 30 days following the injury; or

(5) Work stoppage first occurred six months or more following the injury; or

(6) The technician initially reported the injury after his/her employment had terminated.

b. When persons listed above are otherwise entitled to compensation but are excluded from continuation of pay for the 45-day period, their entitlement to compensation will begin from the date of pay loss, if pay loss is more than 14 days; if pay loss is less than 14 days, compensation begins on the fourth day after pay stops.

c. The employing office may controvert a claim by completing the indicated portion of Form CA-1, "Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," and submitting detailed information in support of the controversion to OWCP.

d. When pay is continued after the technician stops work due to a disabling traumatic injury, it must not be interrupted until:

- (1) The agency receives medical information from the attending physician to the effect that the technician is no longer disabled, or
- (2) The agency receives notification from OWCP that pay should be terminated, or
- (3) At the expiration of 45 days.

2-6 TEMPORARY TOTAL DISABILITY. When an injured technician loses pay due to temporary total disability resulting from a work-related injury or illness, compensation is payable for the injury or illness at the rate of 66 2/3% of the technician's monthly pay. Compensation is increased to 75% of monthly pay if the technician has one or more eligible dependents.

2-7 PERMANENT TOTAL DISABILITY. When a work-related injury causes permanent total disability, compensation is payable until death unless the technician is medically or vocationally rehabilitated. Some examples of injuries that result in permanent total disability are loss of or loss of use of both hands, both arms, both feet, both legs or loss of sight in both eyes. In cases of permanent total disability, compensation is payable at 66 2/3% of the technician's monthly pay and is increased 75% when there is one or more eligible dependents. The technician may receive additional compensation, not to exceed \$500 per month, when the services of an attendant are needed constantly because of a permanent total disability.

2-8 PARTIAL DISABILITY. In cases where the disability is partial, monthly compensation will be equal to 66 2/3% of the difference between the technician's monthly pay and the technician's monthly wage earning capacity after the beginning of the partial disability. Compensation is increased to 75% when there is one or more eligible dependents. A technician who is found to be partially disabled due to work-related injury or illness is not entitled to compensation when he:

- a. Refuses to seek suitable work; or
- b. Refuses or neglects to work after suitable work is offered to, procured by, or secured for him or her.

2-9 SCHEDULE AWARDS. Compensation is provided for a specified period of time for a permanent loss, or loss of use, of each of certain members, organs or functions of the body. Compensation for proportionate periods of time is payable for partial loss of use of each member or organ. The compensation for schedule awards will equal 66 2/3% of the technician's pay or 75% when there is one or more eligible dependents. The schedule of awards is shown in Annex B. In addition, when payment of the scheduled award ceases, the technician is entitled to compensation if the disability continues and the technician is determined to be totally or partially disabled.

2-10 MINIMUM & MAXIMUM COMPENSATION PAYMENTS.

a. Disability Payments. Compensation for disability (including compensation for dependents) may not exceed more than 75% of the monthly pay of the maximum rate of GS-15 and in case of total disability may not be less than 75% of the monthly pay of the minimum rate for GS-02 or the amount of the technician's monthly pay, whichever is less.

b. Death Payments. Compensation for death is computed on a minimum pay equal to the first step of grade 2 of the General Schedule. Total compensation may not exceed 75% of the highest step of grade 15 of the General Schedule except that compensation is allowed to exceed the technician's monthly pay if the excess is created by authorized cost of living increases.

2-11 DEATH

a. Burial. When a technician dies of a job-related injury or illness, a sum not to exceed \$800 may be paid for funeral and burial expenses. If the deceased technician's home is within the United States, an additional sum may be paid for transporting the remains to the home, (if the technician dies away from home, official duty station, or outside the United States). An additional sum of \$200 is paid to the personal representative of a technician who dies of a job-related injury or illness. This sum is for reimbursement of the costs of termination of the technician's status as an employee of the United States government.

b. Dependents. When there are no children entitled to compensation, the technician's widow or widower may receive compensation equal to 50% of the technician's pay until death or remarriage. Upon remarriage, the widow or widower will be paid a lump sum equal to 24 times the monthly compensation being paid on his or her own behalf. If remarriage occurs on or after the age of 60, the lump sum payment will not be made; the compensation will continue until the beneficiary's death. When there is a child entitled to compensation, the compensation for the widow or widower will equal 45% of the technician's pay, plus 15% for each child; total compensation however, may not exceed 75% of the technician's pay. A child is entitled to compensation until he/she dies, marries, reaches 18 years of age; or, if the child is over 18 years of age, compensation will be continued for as long as the child remains a student or until he marries. Compensation may not, however, be continued beyond the end of the semester or the enrollment period after the child reaches 23 years of age or has completed four years of school beyond the high school level.

c. Pay entitlement. On the date of death, a technician is entitled to pay for the entire day, regardless of time of death, provided he/she was in a pay status (including compensable leave) on the workday immediately preceding the day of death. Further, if he/she was in a leave status on the day of death, he/she is not charged leave for that day.

2-12 VOCATIONAL REHABILITATION. Vocational rehabilitation, including job counseling and placement assistance, may be provided to an injured technician who is unable to return to usual employment because of permanent disability due to injury. Additional compensation, not to exceed \$200 per month, may be paid if it is considered necessary for maintenance when the technician is pursuing an approved training course. The technician will be paid at the total disability rate while participating in the approved training course.

2-13 DUAL BENEFITS

- a. As a general rule, a person may not concurrently receive compensation for a job-related injury or illness, and a retirement or survivor annuity from the Office of Personnel Management. The beneficiary has the option to elect the more advantageous of the benefits.
- b. Certain exceptions to this rule are explained in FPM Chapter 831 and FPM Supplement 831-1.
- c. Military retirement/retainer pay and compensation. A technician 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 the reduction of such pay in accordance with 5 USC 5532(b).

CHAPTER 3

FILING A CLAIM

3-1 PROCEDURES. A technician or someone acting on the technician's behalf is required to give written notice of injury to the technician's immediate supervisor. In cases of job-related traumatic injuries, notice of injury must be made on Form CA-1. Nontraumatic occupational injuries or diseases must be reported on Form CA-2. If notice of injury or illness is not submitted within specified time limits, or if the supervisor does not have actual knowledge of the injury or illness, compensation may be denied.

3-2 TIME LIMITS.

a. Report of Injury or Illness. A technician must file notice of injury on Form CA-1 within 2 working days of the injury if treatment of the injury is required. The law requires that the immediate supervisor be notified within 30 days of a traumatic injury that occurred in the performance of duty; otherwise compensation may be denied. In the case of an occupational illness or injury that results in the latent disability, the time for filing notice does not begin to run until the technician has a compensable disability, or the technician by the exercise of reasonable diligence should have been aware of the relationship of the compensable disability to his/her employment. Form CA-2 should be used when filing a claim for occupational illness or injury.

b. Claim for Disability Compensation. An injured technician is required to file a written claim for compensation within three years after the injury before compensation may be paid. If, however, the supervisor had actual knowledge of the injury within 30 days, or if written notice was given within 30 days, compensation is allowed regardless of whether a written claim was made within the three years of the injury. Actual notice must be such as to put the supervisor reasonably on notice of an on-the-job injury or death.

c. Claim for Death Compensation. If the technician dies, a written claim for compensation by or on behalf of the dependents is required before compensation may be paid. This claim is to be filed within three years after the death, unless within 30 days the supervisor had actual knowledge of the death, or written notice was given to the supervisor within 30 days. Also, the timely filing of a disability claim because of an on-the-job injury will satisfy the time requirements for a death claim based on the same injury.

d. Minors and incompetents. The time limitations do not apply to:

- (1) A minor until attaining the age of 21 or until a legal representative is appointed.

(2) An incompetent during a period of incompetency if there is no duly appointed legal representative.

NOTE: The time limitations do not apply in the case of a person whose failure to comply is excused on the ground that the notice could not be given because of exceptional circumstances.

CHAPTER 4

ADMINISTRATION AND RESPONSIBILITIES

4-1 DISTRICT OFFICE. The District Office of Worker's Compensation which adjudicates the claim for New Mexico is:

U.S. Department of Labor
 Employment Standards Administration
 Office of Worker's Compensation Programs
 525 Griffin Square, Room 100
 Dallas, TX 75202

4-2 FORMS. The Support Personnel Management Office will maintain an adequate supply of the following forms. Supervisors are expected to maintain an adequate supply of basic forms needed to record and report on-the-job injuries. SPMO or Publications Officer should be contacted for these forms. (See Annexes C thru P for sample forms).

<u>NO.</u>	<u>TITLE</u>
AGONM Form 810-1	Instructions for Completion of CA-16 - Physician
AGONM Form 810-2	Instructions for Completion of CA-16 - Hospital
CA-1	Federal Employee's Notice of Traumatic injury and Claim for Continuation of Pay/Compensation
CA-2	Federal Employee's Notice of Occupational Disease and Claim for Compensation
CA-3	Report of Termination of Disability and/or Payment
CA-4	Claim for Compensation on Account of Occupational Disease
CA-6	Official Superior's Report of Employee's Death
CA-7	Claim for Compensation on Account of Traumatic Injury
CA-8	Claim for Continuing Compensation on Account of Disability
CA-16	Request for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report
OWCP 1500A	FECA Medical Providing Claim form

4-3 RESPONSIBILITIES OF THE SUPPORT PERSONNEL MANAGEMENT OFFICE The Support Personnel Management Office responsibility is administering the Worker's Compensation program.

- a. To furnish assistance to technicians and supervisors in the interpretation of the rules and regulations covering OWCP.
- b. To review the Forms CA-1 and CA-2 forwarded by employees and supervisors for accuracy and completeness, and to forward these forms to OWCP if injury required examination or medical treatment. If no treatment was required, the forms will be made a permanent record in the technician's Employee Medical Folder.

c. To act as the approving authority for continuation of pay pending OWCP approval. The SPMO will forward the approval and/or disapproval of continuation of pay to the respective payroll office, with an information copy to the supervisor.

4-4 RESPONSIBILITIES OF SUPERVISOR. The responsibilities of each supervisor are as follows:

a. Traumatic Injury Cases:

- (1) To authorize technician medical care.
- (2) To assist technician in preparing Form CA-1, Notice of Injury. A copy of CA-1 is included as Annex E.
- (3) To advise technician of rights to elect continuation of regular pay or annual/sick leave.
- (4) To forward completed CA-1 to SPMO in accordance with Chapter 5 of this regulation.
- (5) To place the technician on an administrative leave status for the absence on the day of the injury.
- (6) To record COP on time and attendance cards as follows:
 - (a) New Mexico Army National Guard - Annotate time and attendance card as "Administrative Leave," using the remarks section to identify the leave as "Continuation of Pay."
 - (b) New Mexico Air National Guard - Follow the procedures outlined in AFM 177-372, Vol II.
- (7) To maintain a log of all actions taken on each on-the-job injury.
- (8) During the forty-five (45) day continuation of pay, to insure that a Duty Status Report, CA-17, is completed by the physician and submitted to SPMO every two weeks. (See Annex M.)
- (9) If disability extends beyond the forty-five (45) days, to ascertain from the technician whether he/she wants to use sick or annual leave or elect to receive compensation. (See Chapter 5, para 5-6, Claims for Compensation. If annual or sick leave is elected, the supervisor should advise the technician on buyback procedures.
- (10) When technician returns to duty after recovery complete Form CA-3 (Annex H) and forward to SPMO.

b. Occupational Disease Cases

(1) Upon receiving notice that a technician has sustained an occupational disease, the supervisor will:

(a) Provide the technician with CA-2 for reporting the occupational disease, and, upon completion, forward the forms to the SPMO. A copy of Form CA-2 is included as Annex F.

(b) Advise the technician to furnish supporting medical evidence and factual information as soon as possible, but not later than five (5) working days following receipt of CA-2. This information must be forwarded to SPMO by the supervisor for further processing.

(c) Advise the technician of the right to elect sick or annual leave pending adjudication of the claim.

4-5 TECHNICIAN RESPONSIBILITIES:

a. Traumatic Injury Cases

(1) When a technician sustains a traumatic, disabling injury in the performance of duty, the employee or someone acting on his behalf must give a written report to the supervisor on Form CA-1. This must be done at the time of the injury, but no later than thirty (30) days thereafter. The individual must indicate on the form whether he elects to receive continuation of regular pay or take annual or sick leave for the period of disability.

(2) The employee will be authorized to obtain medical treatment if required. The employee or his designated representative must inquire from the attending physician the earliest date that he/she can return to work. The technician must furnish this information to his supervisor immediately. If his/her absence from work will last more than two weeks, a Form CA-17 must be completed.

b. Occupational Disease Cases. Technician will notify the supervisor of an occupational disease by completing Form CA-2. This notification must be furnished within thirty (30) days from the day the individual has been informed of the disease by medical authority.

4-6 REPRESENTATION. A claimant may be represented by a union official or any other person on any matter pertaining to an injury or death occurring in performance of duty. This representation must be authorized in writing by claimant. No claim for legal services or for other services rendered in a case, claim, or award of compensation shall be valid unless approved by OWCP.

CHAPTER 5

PROCEDURES FOR PROCESSING CLAIMS

5-1 GENERAL. Upon receiving notice that a technician has sustained a job-related traumatic injury, the supervisor or someone in charge during the absence of the supervisor shall implement the instructions outlined in this chapter.

5-2 AUTHORIZING EXAMINATION AND TREATMENT. The supervisor will authorize the technician an examination and appropriate medical care. Form CA-16 and AGONM TPR Form 810-1 or 810-2 will be issued to a US Medical Officer, hospital, or any duly qualified physician or hospital of the technician's choice.

a. The injured technician has the option to initially select a duly qualified private physician or hospital in the area. Generally speaking, the area is defined as within twenty-five (25) miles of the place of employment or technician's home.

b. When emergency treatment is necessary in cases of traumatic injury, the supervisor may give the technician, physician, or hospital verbal authorization for treatment. Forms CA-16 and OWCP 1500a should be issued within 48 hours thereafter.

5-3 RECORDING OF THE ON-THE-JOB INJURY. The supervisor will provide the technician with a Form CA-1 for completion with instructions to return the form as soon as possible, but no later than thirty (30) days from date of injury. The supervisor will forward the completed CA-1 to the SPMO within two (2) workdays after receipt of form from technician.

5-4 USE OF FORM CA-16 AND RELATED AGONM SPMO FORMS. Use of the Form CA-16 is for injury by accident. It may be used for disease or illness only with the approval of OWCP. An injured technician cannot authorize examination or treatment on his own behalf. It has to be authorized by the supervisor or someone in charge during the absence of the supervisor.

a. If a technician enters the hospital, the supervisor will insure that Form OWCP 1500a and AGONM Form 810-2 accompany the CA-16. The CA-16 together with OWCP 1500a will be forwarded to individual's employing office by the hospital. Part A will be completed by the supervisor. The supervisor will insure that the address in Para 4-1 above is entered in item 12. A sample copy of CA-16 is included in Annex L. Enough copies of CA-16 should be furnished to the hospital, in order that a copy be available to be sent to the SPMO for inclusion in the technician's file.

b. AGONM SPMO Form 810-1 will accompany the CA-16 and OWCP 1500a furnished the attending physician. The form instructs the physician to complete CA-16 and OWCP 1500a and return them to the supervisor. This will be done in order that the supervisor may become aware of the individual's physical condition and the date the technician will be able to return to work. The anticipated period of disability will be reflected in items 29 and 30 of the CA-16. Part A will be completed by the supervisor, who will insure that the mailing address of the technician is entered in item 12. After supervisor reviews the completed CA-16 from physician, he/she will forward the CA-16 to SPMO for further processing.

c. Item 6a should be checked when the supervisor has personal knowledge that the technician was injured while in the performance of duty. Item 6b is to be checked by the supervisor when there is doubt that the technician was injured while in the performance of duty.

5-5 RETURN TO WORK. A technician who was not reported as returning to work on the initial Form CA-1 or 2 must have a Form CA-3 completed upon return to duty. The supervisor will prepare Form CA-3 in duplicate, forward the original to SPMO, and retain the duplicate. A sample copy of CA-3 is contained in Annex H.

5-6 CLAIM FOR COMPENSATION FOR TOTAL TEMPORARY DISABILITY.

a. A technician who is temporarily disabled as the result of an illness or injury causally related to his employment is eligible to claim compensation when approved by OWCP (See Annex B) in the following manner:

- (1) Forty-five (45) day Continuation of Pay for a traumatic injury.
- (2) If the traumatic disability incurred extends beyond the forty-five (45) days, the technician is entitled to $66 \frac{2}{3}$ percent of his regular pay, or 75 percent of pay if he/she has one or more eligible dependents, subject to a three (3) day waiting period and subject to technician being placed on a leave without pay status.
- (3) If disability is due to an occupational disease or illness, technician is entitled to claim compensation as provided for in 5-6b.
- (4) The three-day (3) waiting period does not apply if disability extends more than fourteen days (14) beyond the termination of the forty-five (45) day continuation of pay, or there is permanent disability.

- b. The following procedures will be used to claim compensation:
- (1) Supervisor and technician must complete a CA-4 or CA-7, whichever is applicable. (See samples in Annex I and J).
 - (2) Technician will detach the Form CA-20 and have his physician complete in its entirety (See Annex N). CA-20 is not required if physician has completed a CA-16 within the past ten (10) days prior to the date for which compensation is being claimed.
 - (3) Completed CA-4 or CA-7, along with CA-20, will be forwarded to the SPMO.
 - (4) SPMO will screen for completeness and accuracy, file a copy in the technician's Employee Medical Folder, verify that technician is in a leave without pay status, and forward claim to OWCP for adjudication.

NOTE: Claims for compensation cannot be processed until technician enters a leave without pay status.

c. The technician has the option of electing sick and/or annual leave in order to avoid possible interruption of income between the time his forty-five (45) days expire and the adjudication of the claim. He has the option of buying this leave back (reference para 1-3g). The technician must make this option in letter form and forward the letter with the CA-7 to OWCP.

5-7 CLAIM FOR COMPENSATION FOR CONTINUING DISABILITY. CA 8, along with CA-20a, is used to claim compensation for additional period of pay loss after CA-4 or CA-7 are submitted. Claim on these forms is to be submitted every two weeks until the employee is instructed otherwise. The Form CA-8 will be completed by the technician and the supervisor. One copy of the CA-20a will be issued to the attending physician by the supervisor with instructions to return it to the supervisor as soon as possible. Upon receipt of CA-20a from the physician, the supervisor will forward the CA-8 and CA-20a to SPMO. Sample copies of Forms CA-8 and CA-20a are included as Annexes K and O.

5-8 RECURRENCE OF DISABILITY. A recurrence is defined as occurring when the same injury causes additional time loss from the job. If a technician who has injured his knee and already claimed a traumatic injury returns to work and subsequently falls down and injures the same knee, this would be a new injury and would require a Form CA-1. However, if the technician returns to work and subsequently develops pain to the same knee for no apparent reason or cause other than the previous injury or condition, this would be classified as recurrence and requires Form CA-2a.

a. Traumatic Injury Cases.

(1) If a technician should suffer a recurrence of disability and again stop work, and the initial claim has been approved by OWCP, the supervisor shall promptly complete Form CA-2a. The technician shall advise his supervisor as to whether he/she wishes to continue to receive continuation of pay, if eligible, or charge the absence to sick or annual leave or LWOP. A copy of Form CA-2a is at Annex G.

(2) If the employee elects continuation of pay and is eligible, the supervisor shall again continue regular pay, providing the forty-five (45) calendar days were not all used during the initial period of disability and upon approval by SPMO. This is applicable, however, if no more than 90 days have elapsed since the date employee first returned to work following the initial disability. If a recurrence happens after the six months have expired, continuation of pay is not authorized although some of the forty-five (45) days remain unused. In such instances, the technician can use sick or annual leave or file a claim for compensation. The same provisions also apply once the technician uses all of the forty-five (45) day entitlement. Request for compensation will be made by completing forms:

- a. Form CA-7, if one was not submitted following the original injury. (CA-20 must accompany CA-7).

Forms listed in (a) and (b) above will be forwarded to SPMO.

(3) If the recurrence happens less than six months following the most recent prior medical treatment received by the employee, the supervisor shall authorize required medical care by the use of a CA-16. (Reference para 5-1 and 5-2)

(4) If the recurrence happens more than six months after the most recent prior medical care, supervisor or technician must contact SPMO or request authorization from OWCP. In the event of an emergency, technician should report to the hospital and/or physician and his supervisor will contact SPMO for authorization. If OWCP denies treatment, the technician should file a claim for medical expenses with his medical insurance.

b. Occupational Disease Cases. Following recurrence of disability and work stoppage, the supervisor will complete CA-2a in duplicate and forward original to the SPMO. If the technician does not elect to use sick leave or annual leave and wishes to claim compensation for wage loss, the following forms must be completed:

c. If the technician does not return to duty before CA-2a is submitted an additional report on CA-3 must be submitted to SPMO when the technician returns to work or disability ceases.

5-9 CLAIM FOR COMPENSATION FOR PERMANENT DISABILITY. If the attending physician indicates that technician is permanently disabled in Item 29 of CA-16, or it is determined that the technician is permanently disabled at a later date, the supervisor will notify the SPMO immediately.

5-10 MEDICAL EXPENSES

a. After 9 Jun 1986, OWCP will apply a schedule of maximum allowable payments to many medical services provided by physicians, physical therapists, laboratories, and other providers of medical services (but not services by hospitals, nursing homes and pharmacies). Payments that exceed the maximum allowable fee for a particular service will be automatically reduced by the OWCP billing system. Providers will receive a specific notification of the service reduced and the amount of reduction and will be advised of the provision for requesting an additional amount.

Briefly, an additional amount can be justified if coding was incorrect, if the provider has unusual qualifications (beyond Board certification) or if the patient had conditions which made treatment unusually difficult. The OWCP 1500a and the HCFA 1500 forms both contain wording so that the physician signing the bill agrees to accept OWCP's payment as payment in full. The CA-16 Authorization form stipulates that services are authorized only up to the fee determined by the Government.

b. Doctors and hospitals may send their bills directly to OWCP (para 4-1), on Part B of CA-16 and OWCP 1500a, but the most preferable method is to channel bills through SPMO to OWCP.

c. An employee may claim reimbursement for medical expenses which he/she has paid by sending properly itemized bill to OWCP (Para 4-1) through SPMO. Employees who have already paid the doctor may find that their reimbursement is affected by the fee schedule, and may have difficulty in obtaining the difference from the medical provider. If an employee receives partial reimbursement of a fee for service already paid to the physician, and the notice received with the check says that this was because of a fee schedule reduction, the employee should first contact the physician's office. The physician should be asked to either reimburse the employee, based on OWCP's determination of a maximum allowable fee, or to provide sufficient information to OWCP so that an appeal can be processed. If this does not resolve the issue, the employee should contact OWCP, which will notify the provider of its regulations. Final regulations establishing the fee schedule on 10 March 1986 provide that a provider who, after notification by OWCP of a fee schedule reduction, refuses to refund any amount received from the employee over and above the allowed amount, may be excluded from participation in the program.

d. In the event that OWCP has not paid a claim and individual continues to receive bills, it is the technician's responsibility to send the bills to OWCP through SPMO, making reference to date of injury and claim number, if any.

5-11 REPORT OF DEATH If a technician dies because of an on-the-job injury, the supervisor will immediately telephone the SPMO and initiate CA-6, official supervisor's report of employee's death. This form will notify OWCP of disabled employee's death and should be submitted thru this office.

CHAPTER 6

MISCELLANEOUS

6-1 CIVIL SERVICE RETENTION RIGHTS Employees who have fully or partially recovered from an employment related injury have certain job retention rights. An employee who recovers within one year of beginning compensation or who is considered physically disabled has mandatory restoration rights to his old position or its equivalent, regardless of whether he/she is still on the agency rolls. If full recovery occurs after 1 year, he/she is entitled to priority consideration provided that application is made within 30 days of the date compensation ceases. If the employee is partially recovered, the agency must make every effort to restore him according to the circumstances of the case.

6-2 HEALTH BENEFITS The health benefits enrollment of a technician (and coverage of family members under a family enrollment) who is in receipt of compensation continues automatically if the technician has been enrolled in a plan under the health benefits program; (a) during the five years of service immediately preceding the start of compensation or, (b) during all service since his first opportunity to enroll or, (c) continuously for the full period or periods beginning with the enrollment which became effective no later than December 31, 1964. The technician's share of the health insurance cost will be withheld from compensation.

6-3 LIFE INSURANCE If a technician becomes entitled to benefits from the Office of Worker's Compensation Program (OWCP) for a job-related illness or injury which prevents him from working, he/she may continue his FEGLI coverage as a "compensationeer," including Accidental Death and Dismemberment coverage (AD&D), for up to twelve-months of continuous leave-without-pay (LWOP). The FEGLI life insurance coverage may be continued (AD&D is cancelled) after this twelve month period if:

- a. The technician is receiving benefits from OWCP and is unable to return to duty and,

b. The technician has been insured for the portion of FEGLI he wishes to continue for the 5 years of service immediately preceding the date of his entitlement to benefits from OWCP, or the full period(s) of service during which he/she was eligible for that coverage if less than 5 years. He must continue Basic Life to continue the options. Also, the number of multiples of pay he/she may continue under Option-B Additional is limited to the lowest number of multiples he/she had during the period which meets the above length of participation requirement. Basic Life Insurance is continued without withholdings during the first twelve continuous months of LWOP. The costs for any of the 3 options which he had elected will be withheld from his compensation payments. At the end of 12 months of continuous LWOP (or at separation, if earlier), his FEGLI Insurance will either terminate or be continued for him as a compensationner. In either event, he/she will have the opportunity at that time to convert all or a portion of the insurance coverage(s) for which he/she was insured to an individual direct-pay conversion policy. If eligible to continue coverage, and he/she does not convert, the schedule of withholdings will be made from his compensation payments as if he/she were retired. At the completion of twelve months of LWOP, his employing office will issue him the "Agency Certification of Insurance Status" (SF 2821). He must complete at that time the "Election of Post Retirement Basic Life Insurance Coverage" (SF 2818). FEGLI Life Insurance coverage which is continued for him as a compensationner is subject to the same reductions at age 65 as if he/she were retired.

6-4 DISABILITY RETIREMENT vs COMPENSATION BENEFITS. Except for schedule award disability payments, an injured technician may not receive worker's compensation and an annuity under the Civil Service Retirement Act. Concurrently if the technician is eligible for both annuity and compensation, the technician may elect whichever benefit is most advantageous. If election is made to receive compensation, application for retirement should be made upon separation from technician position, and annuity payments will be suspended during the period the technician is in receipt of compensation. To insure continuation of survivorship protection the technician had under the retirement system, the technician must have made application for disability retirement prior to separation. In addition, the technician's annuity rights will be protected if compensation be discontinued or reduced to a level below the amount the technician would receive for an annuity. If the technician does not wish to apply for retirement, the individual may obtain a lump sum refund of payments from the retirement fund. It should be pointed out that if the technician applies for and receives a refund, the technician will lose all rights to an annuity, and survivors, if any, will not be eligible for survivor benefits.

6-5 EXCUSED ABSENCE. On the day of the injury, leave will not be charged for time spent in receiving initial treatment for an injury incurred in the line of duty, or for the remainder of the duty day during which the injury occurred. However, any subsequent treatments must be charged to sick leave, annual leave or LWOP, unless the technician was on the 45-day continuation of pay.

6-6 BUYBACK OF LEAVE. A technician who has elected sick or annual leave to avoid possible interruption of income pending adjudication of a claim, may arrange to buy back the leave if the claim for compensation is subsequently approved. In such cases, the technician may arrange with the employing agency to buyback the leave and have it reinstated to his account. The compensation to which the technician is entitled would pay a portion of the buy back cost, and the technician would have to pay the balance. The amount of money the technician would be required to pay will depend on several factors, such as the length of the period of disability and the amount of Federal income tax which is withheld from leave pay. The employing agency can help the technician determine how much buy back of leave would cost in each case. A technician who uses leave and decides to buy it back, may do so by filing a claim for compensation (CA-4 and Ca-7) while still in leave status. In the interim the OWCP will consider and resolve any points at issue. Compensation payments will not be made while the technician is in a leave status. Arrangements to buy back leave must be made with the employing agency. The agency may also make arrangements to have compensation paid directly to its account, for the part of the buy back cost which is covered by compensation payments.

6-7 COST OF LIVING INCREASES. Semiannual cost-of-living adjustments are provided under FECA and will be applied to disability compensation and death claims effective March 1 and September 1. The method of computation and administration for the adjustments are basically the same as those used for Civil Service annuitants.

6-8 PENALTIES.

a. The Federal Employees Compensation Act imposes severe penalties upon persons accepting payments of compensation to which they are not entitled. Penalties are provided for supervisors or technicians charged with the responsibility for making reports who willfully fail, neglect or refuse to make any such reports, or who knowingly file a false report, or induce, or direct any injured technician to forego filing a claim for compensation, or who willfully and wrongly retain any notice, report, claim or paper which is required under the Compensation Act. Such offenses are misdemeanors and are punishable for a fine of no more than \$500 or imprisonment for no more than one year, or both.

b. Any person who makes a false statement to obtain Federal Employees' Compensation, or who accepts compensation payments to which he/she or she is not entitled is subject to a fine of no more than \$2,000, or imprisonment for no more than one year, or both.

CHAPTER 7

HEARINGS, RECONSIDERATIONS & APPEALS

7-1 RECONSIDERATION. If a claimant has evidence which he/she believes to be pertinent, he may at any time ask for reconsideration of the decision. No special form is required, but the request must be in writing and state clearly the grounds upon which reconsideration is requested. Also, the request must be accompanied by evidence not previously submitted, such as medical reports, affidavits, or statements. In order to insure that the claimant receive a new and independent evaluation of the evidence, the case will be reconsidered by persons other than those who made the original determination. Request for reconsideration, along with the new evidence, should be addressed to the Director, Office of Worker's Compensation Programs (OWCP), Washington, D.C. 20211.

7-2 HEARINGS: If injury occurred on or after July 4, 1966, claimant may ask for a hearing before an OWCP representative within 30 days after the date of the decision. At the hearing, he/she will be afforded an opportunity to present evidence, either oral or written, in further support of his claim. The hearing will be informal and will be held at a convenient location. Claimant may be represented at the hearing by any person authorized by claimant in writing. As soon as possible after the hearing, a copy of the OWCP representative's decision will be mailed to claimant. Claimant will have the right to appeal this decision. The request for hearing should be addressed to the Director, Office of Worker's Compensation Programs (OWCP), Washington, D.C. 20311.

7-3 APPEALS. If the claimant believes that all available evidence has been submitted, he/she has the right to appeal to the Employees' Compensation Appeals Board for review of the decision. Review by the Appeals Board is limited to the evidence of record. No new evidence may be submitted to the Board. Request for review by the Appeals Board should be made within 90 days from the date of the enclosed compensation order and should be addressed to the Employees' Compensation Appeals Board, Washington, D.C. 20210. If claimant should request a hearing or reconsideration by the Office of Workers' Compensation Programs as indicated above, the 90-day period within which he/she may request review by the Appeals Board will run from the date of any later decision by the OWCP. If good cause is shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of this decision.

FOR THE ADJUTANT GENERAL:


RUDY F. GONZALES, GM-13
Personnel Officer

DISTRIBUTION:

ARNG - A, B, C, F, G, H, I
ANG - 50
NFFE - 25
CSMS - 8
MATES - 6
NMAG-SP - 20

ANNEX A

US MEDICAL FACILITIES AVAILABLE

US Medical Facilities Available:

a. USAF Hospital KAFB (New Mexico Air National Guard Technicians).-

(1) Minor Emergencies not requiring an ambulance.

(a) During duty hours (0715 - 1600): Notify your supervisor and the Air National Guard Clinic. Have your supervisor or commander complete a Form CA-16 for all injuries other than those requiring first aid treatment. Then report to the East hospital for treatment. Identify yourself as a Civil Service Employee. Civilian Health Care Records are maintained in the hospital's Outpatient Record Section. The treatment given will be recorded in your records.

(b) After hours (1600 - 0715): Notify your supervisor and report to the East Hospital Room for treatment. Identify yourself as a Civil Service Employee whose medical records are maintained by the hospital.

(2) Major emergencies requiring an ambulance. 24 hours ambulance service is available by calling the hospital Emergency Room at 844-4611/3410. The individual's supervisor and the Air Guard Clinic are to be notified.

b. William Beaumont Army Medical Center (New Mexico Army National Guard Technicians located at Dona Ana Range Camp).

(1) Minor Injuries/Emergencies. Injured technicians will be transported if necessary to William Beaumont by the MATES Superintendent or his designee.

(2) Major Emergencies. The MATES Superintendent or his designee will call the William Beaumont Army Medical Center (telephone: 568-8900 or 568-8833 or MEDIVAC Helicopter service if conditions so dictate.

(3) Form CA-16 will be issued to William Beaumont Army Medical Center for every on-the-job injury treatment at the Center.

ANNEX B

SCHEDULE OF AWARDS

Permanent Partial Disabilities. When an injured technician suffers the permanent loss or use of certain functions of the body, the Federal Employees' Compensation Act provides for disability compensation for specified period of time. The table below shows the number of weeks a scheduled award may be paid for specific partial disabilities.

TABLE OF SCHEDULED AWARDS

Injury resulting in the loss of:	Weeks of Compensation
(1) 1 arm	312
(2) 1 leg	288
(3) 1 hand	244
(4) 1 foot	205
(5) 1 eye	160
(6) thumb	75
(7) first finger	46
(8) great toe	38
(9) second finger	30
(10) third finger	25
(11) toe other than great toe	16
(12) fourth finger lost	15
(13) complete loss of hearing one ear	52
(14) complete loss of hearing both ears	200
(15) Serious disfigurement of the face, head or neck, of a character likely to handicap an individual in securing or maintaining employment, proper and equitable compensation not to exceed \$3500 shall be awarded in addition to any other compensation payable under this schedule.	
(16) Permanent loss or loss of use of any other important external or internal organ of the body as determined by the Secretary of Labor, proper and equitable compensation not to exceed 312 weeks for each organ so determined shall be paid in addition to any other compensation payable under this schedule.	

Permanent Total Disabilities. When technicians become totally disabled, they may receive benefits for the rest of their life. Some types of injuries are considered sufficient evidence of total disability; these include loss of both hands, both arms, both legs, both feet, or both eyes. Other situations require a determination based upon medical findings.

ANNEX C

Instruction for Completion of Form CA-16

FOR

Physicians

TO: ENTER NAME AND ADDRESS OF PHYSICIAN

NAME

ADDRESS

CITY, STATE AND ZIP CODE

1. Attached is one copy of Form CA-16, Request for Examination and/or treatment and 2 copies of OWCP 1500a, FECA Medical Providing Claim Form on _____ of _____ an employee of the New Mexico National Guard. He is a Federal Employee who sustained an injury while in the performance of his duties.

2. Please complete the reverse side of the Form CA-16. The completion of Items # 29 and # 30 are of extreme importance. If employee is disabled for one or more days, he/she will be entitled to Workers' Compensation Benefits.

3. In order that employees receive all benefits, respectfully request that the copy of the Form CA-16 be returned to me at the following address.

ENTER ADDRESS OF THE PLACE OF TECHNICIAN'S EMPLOYMENT, ATTN: SUPERVISOR CONCERNED:

NAME

ADDRESS

CITY, STATE AND ZIP CODE

4. Attached OWCP 1500a to the original Form CA-16, which will be forwarded to the Office of Workers' Compensation by the Office of Military Affairs. To expedite consideration of the charges and to reduce administrative costs, attention should be given to the following instructions.

a. OWCP 1500a is a billing mechanism and is not intended to replace required narrative medical reports, therefore, it should be completed in accordance with instructions on reverse side of form.

b. Statements should be itemized to clearly show dates of treatment, character of services or supplies, the amount charged for each.

(1) Charges for x-rays should show number of views and parts of body x-rayed.

(2) Sales tax is not a proper charge against the Federal Employees Compensation Fund.

c. A separate statement should be submitted for services, and/or supplies furnished each injured employee. If you have paid another person, corporation or firm for services and/or supplies, the amount so paid may be included in your statement if accompanied by an itemized statement in duplicate, properly receipted in your favor.

d. Statements should be submitted when the injured employee is discharged from treatment, except when treatment extends for more than thirty (30) days. In the later event, statements may be submitted at the end of each thirty (30) days.

SIGNATURE OF SUPERVISOR

DATE

ANNEX D

Instructions for Completion of Form CA-16

FOR

HOSPITAL

ENTER THE NAME AND ADDRESS OF HOSPITALADDRESSCITY, STATE AND ZIP CODE

1. Attached are two (2) copies of Form CA-16, Request for Examination and/or treatment and 2 copies of OWCP 1500a, FECA Medical Providers Claim Form.
2. Please complete the reverse side of Form CA-16 and forward to the following addresses:

One Copy to:

U.S. Department of Labor
Office of Federal Employees
Compensation Programs
525 Griffin Square, Room 100
Dallas, TX 75202

One Copy to:

Enter Technicians Place of
Employment

ADDRESSCITY, STATE AND ZIP CODE

3. Attached OWCP 1500a to Form CA-16 and forward with OWCP copy sent to Dallas. To expedite consideration of the charges and to reduce administrative costs, attention should be given to the following instructions.

a. OWCP 1500a should be itemized to clearly show dates of treatment, character of services or supplies, and amount charged for each OWCP 1500a is a billing mechanism and is not intended to replace required narrative medical reports.

(1) Charges for x-rays should show number of views and parts of body x-rayed.

(2) Bill for services of special nurses, consultants, and for medicine, drugs, orthopedic, prosthetic and other appliances, physiotherapy, etc., should be approved by the physician in charge unless they were specifically authorized by the OWCP.

(3) Sales tax is not a proper charge against the Federal Employees Compensation Fund.

b. A OWCP 1500a should be submitted for services and/or supplies furnished each injured employee. If a doctor or hospital has paid another person, corporation, or firm for services and/or supplies, the amount so paid may be listed in item 24 or OWCP 1500a, if accompanied by an itemized statement in duplicate, properly receipted in favor of the hospital.

c. OWCP 1500a should be submitted when the injured employee is discharged from treatment, except when treatment extends for more than thirty (30) days. Items 28 and 29 relate to statements with a remaining balance, if previously submitted, indicate in item 24 column F.

SIGNATURE OF SUPERVISOR

NAME

ATTACHMENT TO CA-1

Following remark applies to:

Block 33 of CA-1
Block 43 of CA-2
Block 14 of CA-2a
Block 33 of CA-7
Block 16 of CA-8

Enter "NOT APPLICABLE" (N/A/) if technician did not stop work. If technician stopped work enter date he/she returned to work or if he/she has not returned enter "HAS NOT RETURNED".

Following remark applies to:

Block 40 of CA-1

If "YES" block is checked the medical report (CA-16) must verify the disability which prevents technician from returning to work, before continuation of pay benefits will be authorized.



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



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) SELF EXPLANATORY		2. Social Security Number SELF EXPLANATORY	
3. Date of birth Mo. Day Yr. SELF EXPLANATORY	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female SELF EXPLANATORY	5. Home telephone () EXPLANATORY	6. Grade as of date of injury Level Step SELF EXPLANATORY
7. Employee's home mailing address (Include city, state, and zip code) SELF EXPLANATORY			8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other SELF EXPLANATORY

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
BE SPECIFIC AND AS DETAILED AS POSSIBLE

10. Date injury occurred Mo. Day Yr. SELF EXPLANATORY	Time SELF EXPLANATORY <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr. SUPV NOTIFIED	12. Employee's occupation SELF EXPLANATORY
---	---	---	---

13. Cause of injury (Describe what happened and why)
BE SPECIFIC AND AS DETAILED AS POSSIBLE

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg) BE SPECIFIC AND AS DETAILED AS POSSIBLE	a. Occupation code LEAVE BLANK
	b. Type code c. Source code LEAVE BLANK
	d. OWCP Use - NOI Code LEAVE BLANK

Employee Signature

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

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

b. Sick and/or Annual Leave

NOTE: Technician must elect leave or Continuation of Pay and sign this block. Supervisor must explain Continuation of Pay to employee.

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

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 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.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury)
ANY AND ALL WITNESSES SHOULD SUPPLY STATEMENTS. ATTACH ADDITIONAL STATEMENTS IF NECESSARY.

Signature of witness SELF EXPLANATORY	Signature of witness SELF EXPLANATORY	Date signed SELF EXPLANATORY
Address SELF EXPLANATORY	City SELF EXPLANATORY	State Zip Code SELF EXPLANATORY

Supervisor's Report

17. Agency name and address of reporting office (Include city, state, and zip code)
Department of Military Affairs
ATTN: NMAG-SP
PO Box 4277
Santa Fe, NM 87502-4277
OWCP Agency Code LEAVE BLANK
OSHA Site Code LEAVE BLANK
Zip Code

18. Employee's duty station (Street address and zip code)
SELF EXPLANATORY
Zip Code

19. Regular work hours From: To:
20. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.
ENTER CIVILIAN TIME
SELF EXPLANATORY

21. Date of injury Mo. Day Yr.
22. Date notice received Mo. Day Yr.
23. Date stopped work Mo. Day Yr.
ENTER CIVILIAN TIME
SELF EXPLANATORY

24. Date pay stopped Mo. Day Yr.
25. Date 45 day period began Mo. Day Yr.
26. Date returned to work Mo. Day Yr.
ENTER CIVILIAN TIME
SELF EXPLANATORY

27. Was employee injured in performance of duty? Yes No (If "No," explain)
SELF EXPLANATORY

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes No (If "Yes," explain)
SELF EXPLANATORY

29. Was injury caused by third party? Yes No (If "No," explain)
30. Name and address of third party (Include city, state, and zip code)
SELF EXPLANATORY

31. Name and address of physician first providing medical care (Include city, state, zip code)
SELF EXPLANATORY
32. First date medical care received Mo. Yr.
SELF EXPLANATORY
33. Do medical reports show employee is disabled for work? Yes No
SELF EXPLANATORY

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? Yes No (If "No," explain)
SELF EXPLANATORY

35. Does the employing agency controvert continuation of pay? Yes No (See instructions for explanation of "controvert")
SEE INSTRUCTIONS FURNISHED AS PART OF FORM BEFORE COMPLETION.
36. Pay rate when employee stopped work \$ Per
SELF EXPLANATORY

Signature of Supervisor and Filing Instructions

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

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

SELF EXPLANATORY

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office 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
SELF EXPLANATORY

Notice of Occupational Disease and Claim for Compensation

J.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) SELF EXPLANATORY				2. Social Security Number SELF EXPLANATORY	
3. Date of birth Mo. Day Yr. SELF EXPLANATORY	4. Sex	5. Home telephone () SELF EXPLANATORY	6. Grade as of date of last exposure SELF EXPLANATORY Level Step		
7. Employee's home mailing address (Include city, state, and zip code) SELF EXPLANATORY				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other IF NONE SO INDICATE	
				Zip Code	

Claim Information

9. Employee's occupation ENTER PROPER TITLE		a. Occupation code LEAVE BLANK
10. Location (address) where you worked when disease or illness occurred (Include city, state, and zip code) BE SPECIFIC		11. Date you first became aware of disease or illness Mo. Day Yr. SELF EXPLANATORY
12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr. SELF EXPLANATORY	13. Explain the relationship to your employment, and why you came to this realization BE SPECIFIC AND AS DETAILED AS POSSIBLE	

14. Nature of disease or illness BE SPECIFIC	OWCP Use - NOI Code LEAVE BLANK	
	b. Type code LEAVE BLANK	c. Source code LEAVE BLANK

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.
SELF EXPLANATORY

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
SELF EXPLANATORY

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
SELF EXPLANATORY

Employee Signature

18. I certify, under penalty of law, that 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 intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

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

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

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

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

19. Agency name, and address of reporting office (include city, state, and zip code)
 Department of Military Affairs
 Attn: NMAG-SP, PO Box 4277, Santa Fe, NM 87501-4277
 OSHA Site Code LEAVE BLANK
 OWCP Agency Code LEAVE BLANK
 Zip Code

NOTE: THIS IS THE ONLY AUTHORIZED AGENCY NAME AND ADDRESS
 20. Employee's duty station (Street address and zip code)
 BE SPECIFIC
 Zip Code
 21. Regular work hours From: a.m. To: p.m.
 22. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.
 SELF EXPLANATORY

23. Name and address of physician first providing medical care (include city, state, zip code)
 SELF EXPLANATORY
 24. First date medical care received Mo. Day Yr.
 25. Do medical reports show employee is disabled for work? Yes No
 SELF EXPLANATORY

26. Date employee first reported condition to supervisor Mo. Day Yr.
 27. Date and hour employee stopped work Mo. Day Yr. Time
 28. Date and hour employee's pay stopped Mo. Day Yr. Time
 29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr. Time
 SELF EXPLANATORY

30. Date returned to work Mo. Day Yr. Time
 31. If employee has returned to work and work assignment has changed, describe new duties
 SELF EXPLANATORY

32. Was injury caused by third party? Yes No
 If "No," go to item 34.
 33. Name and address of third party (include city, state, and zip code)
 SELF EXPLANATORY

Signature of Supervisor
 34. A supervisor who knowingly certifies to any false statement, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.
 I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
 SELF EXPLANATORY

Name of Supervisor (Type or print)
 Signature of Supervisor
 Date
 Office phone
 Supervisor's Title

Notice Of Employee's Recurrence Of Disability
And Claim For Pay/Compensation

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



IMPORTANT: Before completing this form please read carefully the instructions.

PART A – EMPLOYER

1. NAME OF INJURED EMPLOYEE (last, first, middle) SELF EXPLANATORY		2. SOCIAL SECURITY NUMBER SELF EXPLANATORY		3. OWCP file number for original injury (if known) SELF EXPLANATORY	
4. HOME MAILING ADDRESS (include zip code) SELF EXPLANATORY				5. HOME TELEPHONE Area Code SELF Number EXPLANATORY	
6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury (number, street, city, state, zip code) Department of Military Affairs Attn: NMAG-SP PO Box 4277, Santa Fe, NM 87502-4277			7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6. SELF EXPLANATORY		
8. DATE AND HOUR of original injury (mo., day, year) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. ENTER CIVILIAN <input type="checkbox"/> p.m.		9. DATE AND HOUR of recurrence (mo., day, year) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. ENTER CIVILIAN <input type="checkbox"/> p.m.		10. DATE AND HOUR stopped work following recurrence (mo., day, year) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. ENTER CIVILIAN <input type="checkbox"/> p.m.	
11. DATE AND HOUR pay stopped following recurrence (mo., day, year) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. ENTER CIVILIAN <input type="checkbox"/> p.m.					
12. PAY RATE IN EFFECT ON:		a. Base pay	b. Subsistence	c. Quarters	d. Other pay
A. Date of Recurrence		ENTER AMOUNT \$ per	ENTER NA \$ per	ENTER NA \$ per	DRILL PAY IF ANY \$ per
B. Date Stopped Work Following Recurrence		\$ per	\$ per	\$ per	\$ per
13. Show work week at time pay stopped, if other than Monday thru Friday S M T W T F S SELF EXPLANATORY		14. DATE AND HOUR returned to work, following recurrence (mo., day, year) <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. ENTER CIVILIAN TIME <input type="checkbox"/> p.m.		15. At time of recurrence did official superior authorize medical treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO ENTER YES IF CA 16 WAS ISSUED	
16. DATE employee first received medical treatment following recurrence (mo., day, year) SELF EXPLANATORY		17. NAME AND ADDRESS of physician treating employee following recurrence SELF EXPLANATORY			
18. After returning to work following the original injury, was the employee handicapped or in any way limited in performing his/her usual duties? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, explain) SELF EXPLANATORY					
19. Describe the circumstances of the recurrence of disability as reported by the employee. If the condition gradually worsened over a period of time, describe the progress of the condition from the time employee returned to work up to the date of recurrence. BE AS SPECIFIC AND AS DETAILED AS POSSIBLE					
A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.					
20. Signature of official superior (at time of recurrence) SELF EXPLANATORY		21. Title SELF EXPLANATORY		22. Official superior's work phone number SELF EXPLANATORY	23. Date (mo., day, year)

PART B - CONTINUATION OF PAY

24. Inclusive dates that employee's regular pay continued during this period of recurrence. Do not include period of sick or annual leave.

ENTER COP USED IF ANY

From: Through:

SELF EXPLANATORY

25. Show gross dollar amount of regular pay which employee received during this period of recurrence.

26. If pay changed during the period employee was receiving continuation of pay, for this recurrence, show date of change (mo., day, yr.).

SELF EXPLANATORY

a. Base Pay

b. Subsistence

c. Quarters

d. Other (specify)

PART C - EMPLOYEE

28. Complete this item if you worked during the period shown in item 29(b) or 29(c).

a. Dates & Hours Worked

b. Pay Rate (per hour, day or week)

c. Total Amount Earned

d. Type Work Performed

e. Name & Address of Employer

SELF EXPLANATORY

29. I certify that the recurrence claimed on date in item 9 was due to the injury shown in item 8 and I hereby claim medical treatment, if needed, and the following as checked below, while disabled for work:

a. Sick and/or annual leave

b. Continuation of regular pay not to exceed 45 days, which will include days taken during the original injury and prior recurrence(s), 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).

c. Continuing compensation on account of occupational disease.

SELF EXPLANATORY

30. Signature of Employee or Person Acting on his/her behalf. 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.

31. Date (Month, day, year)

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

REPORT OF TERMINATION OF DISABILITY
AND/OR PAYMENT

PART - A GENERAL

1. Name of Injured Employee (<i>Last, first, middle</i>) ENTER INFORMATION:		2. Social Security Number ENTER INFORMATION	3. OWCP File Number (<i>If known</i>) ENTER INFORMATION
4. Department or Agency NEW MEXICO <u>NATIONAL GUARD</u>		5. Bureau or Office NEW MEXICO <u>ARMY</u> OR <u>AIR</u> NATIONAL GUARD	
6. Name and Address of Reporting Office (<i>Include Zip Code</i>) Office of Military Affairs, ATTN: NMAG-SEMO, PO BOX 4277, SANTA FE, NEW MEXICO 87501			
7. Date and Hour of Injury (<i>Mo., day, year</i>) SAME DATE <input type="checkbox"/> AM AS ON CA-1 <input type="checkbox"/> PM	8. Date and Hour Stopped Work (<i>Mo., day, year</i>) SAME INFO AS ON <input type="checkbox"/> AM CA-1, 2, or 2a <input type="checkbox"/> PM	9. Date and Hour Pay Stopped (<i>Mo., day, year</i>) SAME INFO AS ON <input type="checkbox"/> AM CA-1, 2, or 2a <input type="checkbox"/> PM	10. Date and Hour Returned to Work (<i>Mo., day, year</i>) ENTER INFORMATION <input type="checkbox"/> AM <input type="checkbox"/> 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 (<i>Specify</i>)		
13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of: a. Annual Leave b. Sick Leave c. Other (<i>Specify</i>) From: ENTER IF APPLICABLE From: ENTER IF APPLICABLE From: ENTER DATES OF COP IF APPLICABLE Through:			
14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Describe The Type of Work Employee Is Performing. ENTER INFORMATION			
15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (<i>Mo., day, year</i>) <u>Health Benefit</u> <u>Optional Insurance</u> LEAVE BLANK	16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (<i>Mo., day, year</i>) LEAVE BLANK Number _____ Date _____		
17. Remarks:			

PART - B CONTINUATION 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 (<i>Mo., day, year</i>) ENTER DATES FROM BLOCK 13 c. 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 or annual leave. SHOW GROSS PAY RECEIVED FOR THOSE DATES IN BLOCK 13. \$		
20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (<i>Mo., day, year</i>) ENTER INFORMATION or N/A	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 (<i>Specify</i>)		
22. Signature of Supervisor SELF EXPLANATORY	23. Title and Office Phone Number SELF EXPLANATORY	24. Date (<i>Mo., day, year</i>) COMPLETE	

INSTRUCTIONS FOR COMPLETING FORM CA-3
WHEN EMPLOYEE RETURNS TO WORK

PART - A

- When disability ceases and/or employee returns to work, the official supervisor shall immediately report that 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 resulting in time lost from work whether or not claim for compensation is made.

- If the employee is receiving disability compensation periodically each four weeks, the official supervisor 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.

- 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

- In most traumatic injury cases, the employee will have qualified for and received continuation of pay under 5 USC 8118 (FECA). When this occurs, items 9, 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-7. Claim for Compensation on Account of Traumatic Injury.

REQUIRED
WRITTEN
REPORT

TELEPHONE/
TELEGRAPH
REPORT

PAY RATE
INFORMATION

CONTINUATION
OF PAY

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price \$2.75 per 100

Stock Number 029-016-00024

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		CLAIM FOR COMPENSATION ON ACCOUNT OF OCCUPATIONAL DISEASE		
1. NAME (Last, First, Middle) ENTER INFORMATION		2. HOME MAILING ADDRESS (Number, Street, State, and Zip Code) ENTER ADDRESS OF TECHNICIAN		
3. DATE YOU FIRST BECAME AWARE OF DISEASE OR ILLNESS (Mo., Day, Year) ENTER INFORMATION FROM BLOCK 13 OF CA-2		4. IF YOU LOST PAY, SHOW PERIOD COMPENSATION IS CLAIMED (Mo., Day, Year) FROM: ENTER INFORMATION TO:		
5. SHOW AMOUNT OF ALL WAGES RECEIVED FROM ANY SOURCE DURING PERIOD SHOWN IN ITEM 4 ALSO GIVE EMPLOYER'S NAME AND ADDRESS IF OTHER THAN FEDERAL GOVERNMENT ENTER INFORMATION OR N/A				
6. WERE YOU EVER IN THE ARMED FORCES OF THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FURNISH →	A. SERVICE NUMBER	B. NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED	C. PERIOD OF SERVICE FROM _____ THROUGH _____	
7. HAVE YOU EVER APPLIED FOR OR RECEIVED BENEFITS FROM THE VA BASED ON SERVICE IN THE ARMED FORCES OF THE UNITED STATES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FURNISH →	A. CLAIM NO.	B. VA ADDRESS WHERE CLAIM IS FILED	C. NATURE OF DISABILITY AND MONTHLY PAYMENT \$ _____	
8. HAVE YOU APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE U.S. CIVIL SERVICE OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW? ENTER INFORMATION <input type="checkbox"/> YES <input type="checkbox"/> NO OR N/A IF YES, FURNISH →	A. CLAIM NO.	B. DATE ANNUITY BEGAN (Mo., Day, Year)	C. AMOUNT OF MONTHLY PAYMENT \$ _____	
9. DATE YOU FIRST REALIZED THE DISEASE WAS CAUSED OR AGGRAVATED BY YOUR EMPLOYMENT. (Mo., Day, Year) EXPLAIN WHY YOU CAME TO THIS REALIZATION ENTER DATE AND BRIEF STATEMENT				
10. LIST YOUR DEPENDENTS (If none so state)				
NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT LIVING WITH YOU? YES NO	IF NOT SHOW MAILING ADDRESS
ENTER INFORMATION OR N/A	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
11. SHOW AMOUNT PAID EACH MONTH FOR SUPPORT OF DEPENDENTS NOT LIVING WITH YOU STATE WHETHER PAYMENTS WERE ORDERED BY A COURT AND IF SO ATTACH A COPY OF THE COURT ORDER \$ _____ ENTER INFORMATION OR N/A				
I CERTIFY THAT THE DISEASE OR ILLNESS DESCRIBED ABOVE WAS A 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 INTOXICATION. I HEREBY CLAIM MEDICAL TREATMENT IF NEEDED AND OTHER BENEFITS PROVIDED BY THE FEDERAL EMPLOYEES COMPENSATION ACT				
12. YOUR SIGNATURE OR SIGNATURE OF PERSON ACTING FOR YOU SELF EXPLANATORY			DATE (Mo., Day, Year)	

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)
 ENTER INFORMATION

NOTE: DOCTOR OR HOSPITAL MUST COMPLETE THE
 REMAINDER OF THIS FORM.

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? (If yes, please describe)
 Yes No

17. What Are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

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?
 If yes, date of admission (Mo., day, year)
 Yes No

21. Is Additional Hospitalization Required?
 Yes No

22. Surgery (If any, describe type)

23. 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(s) 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 Regular Work
 Date: _____ 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 Extent of Physical Limitations and the Type of Work That Could Reasonably be Performed with These Limitations.

33. General 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

**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 SELF EXPLANATORY			2. OWCP File Number ENTER OWCP CASE NR			
Social Security Number SELF EXPLANATORY		4. Period of wage loss for which compensation is claimed From mo. day yr. Thru mo. day yr. ENTER PERIOD OF LWQP		Hours		
6. Has any pay been received for period shown in item 4? ENTER NO <input type="checkbox"/> Yes <input type="checkbox"/> No			7. If yes, amount ENTER NA		5. Is this a claim for a schedule award? <input type="checkbox"/> Yes <input type="checkbox"/> No ENTER NO	
8. Was claim made against 3rd party? SELF EXPLANATORY <input type="checkbox"/> Yes <input type="checkbox"/> No			9. Name of 3rd party or insurance carrier SELF EXPLANATORY			
10. Has the claim been settled? Give amount recovered. SELF EXPLANATORY			Address City State Zip			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No ENTER INFORMATION OR NA 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? <input type="checkbox"/> Yes <input type="checkbox"/> No ENTER INFORMATION OR NA If Yes, furnish ▶			a. Claim number	b. Date annuity began mo. day yr.	c. Amount of monthly payment \$	

Dependents

13. List your dependents

Name	Date of Birth mo. day yr.	Relationship	Living with you? (yes/no)	Mailing Address, if different from your own
SELF EXPLANATORY				

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? If so, attach copy of court order. Yes No

16. If yes, 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 because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. 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 every 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 felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both.

Employee's signature SELF EXPLANATORY Date (Mo., day, year)

Employee's home mailing address (Include Zip Code)
SELF EXPLANATORY

City State Zip

Statement of Official Superior

20. Pay Rate As Of:		Date of Injury		Date Employee Stopped Work	
a. Base Pay	ENTER BI-WEEKLY \$ per	b. Subsistence	ENTER NA \$ per	c. Quarters	ENTER NA \$ per
d. Other (Specify)	ENTER NA \$ per				

21. If employee received additional pay, identify type and show amount		22. Show work schedule for week pay stopped	
Premium	ENTER NA per	Sun	<input type="checkbox"/>
Pay	ENTER NA per	Mon	<input type="checkbox"/>
Sunday	ENTER NA per	Tue	<input type="checkbox"/>
Pay	ENTER NA per	Wed	<input type="checkbox"/>
Other (Identify) IF APPLICABLE OR NA	ENTER NA per	Thu	<input type="checkbox"/>
IF APPLICABLE	ENTER AMOUNT IF APPLICABLE per	Fri	<input type="checkbox"/>
		Sat	<input type="checkbox"/>

23. Did employee work in position for 11 months prior to injury?		24. If not, would position have afforded employment for 11 months but for the injury?	
Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
No	<input type="checkbox"/>	No	<input type="checkbox"/>

25. Total length of federal civilian service		26. Was the employee enrolled in a Health Benefits Program on the date pay stopped?	
Yrs. Mos.	SELF EXPLANATORY	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>

27. Was the employee enrolled in an Optional Life Insurance Program on the date pay stopped?		28. Type and inclusive dates employee received leave for any part of period since stopping work.	
Yes	<input type="checkbox"/>	Type of Leave	From mo. day yr. Thru mo. day yr.
No	<input type="checkbox"/>	Type of Leave	From mo. day yr. Thru mo. day yr.

29. If employee received continuation of pay (COP), give dates.		30. Date all pay stopped	
From	Thru	Hour	mo. day yr. ENTER DAY BEFORE
From	Thru	Hour	mo. day yr. ENTER CIVILIAN TIME

31. Period for which compensation is claimed		32. Date returned to work	
From mo. day yr.	Thru mo. day yr.	Hour	mo. day yr. SELF EXPLANATORY
From mo. day yr.	Thru mo. day yr.	Hour	mo. day yr. SELF EXPLANATORY

33. Work schedule when returned to work		34. Did the work assignment change because of disability resulting from the injury?	
Sun	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Mon	<input type="checkbox"/>	No	<input type="checkbox"/>
Tue	<input type="checkbox"/>	Describe.	
Wed	<input type="checkbox"/>	35. Pay rate on return to work	
Thu	<input type="checkbox"/>	Per	
Fri	<input type="checkbox"/>		
Sat	<input type="checkbox"/>		

36. 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.		37. If OMC needs specific pay information the person who should be contacted is	
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:		Supervisor	

Signature of supervisor _____ Date _____

Supervisor's title _____

Agency name & address _____

Office phone _____

Phone _____

Supervisor Other: Name _____

Supervisor Other: Name _____

SELF EXPLANATORY

SELF EXPLANATORY

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

CLAIM FOR CONTINUING COMPENSATION
ON ACCOUNT OF DISABILITY

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE (Last, first, middle) ENTER INFORMATION		2. OWCP FILE NUMBER, IF KNOWN ENTER INFORMATION
3. HOME MAILING ADDRESS (Include zip code) ENTER ADDRESS OF TECHNICIAN		4. SOCIAL SECURITY NUMBER ENTER INFORMATION

5. DATE AND HOUR OF INJURY (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM GET DATE FROM CA-1, CA-2, or CA-2a	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) Enter period of LwOP FROM: THROUGH:
--	--

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF YES, COMPLETE ITEM 8. ENTER INFORMATION	8. AMOUNT RECEIVED \$ _____ DATES COVERED BY LEAVE PAY ENTER FROM: THROUGH: OR N/A
--	---

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER
ENTER INFORMATION OR N/A				

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING: ENTER INFORMATION OR N/A

REGISTRATION NO.:	DATE OF REGISTRATION	OFFICE ADDRESS
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11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

ENTER INFORMATION OR N/A

12. 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:

ENTER INFORMATION OR N/A	NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED
CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT	

13. 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
ENTER INFORMATION OR N/A	

SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF : SELF EXPLANATORY	15. DATE (Mo., day, year) COMPLETE
--	------------------------------------

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR SEE REMARK (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM ON ATTACHMENT TO SAMPLE CA-1	
17. SHOW EMPLOYER'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY S M T W T F S	18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6, ON THE REVERSE SIDE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHECK APPLICABLE BOX
18. IF ANSWER TO ITEM 18, IS YES, SHOW: AMOUNT: \$ ENTER INFORMATION OR N/A TYPE OF PAYMENT: _____ PERIOD: FROM: _____ THROUGH: _____	20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYER'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. (i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)

21. REMARKS

ENTER INFORMATION OR N/A

COMPLETE IF APPLICABLE

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE (Mo., day, year)
SELF EXPLANATORY	SELF EXPLANATORY	COMPLETE

INSTRUCTIONS FOR INJURED EMPLOYEE

- Items 1, through 15, 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.
- The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency.
- Employees are advised that fraudulent claims are punishable by a fine of not more than \$2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

- The official superior must complete items 16, through 24, and forward the form to the appropriate OWCP office.
- The official superior must also complete items 1, through 6, on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3, on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.



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 this 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 Cir. No. A-108.

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

ENTER INFORMATION

2. Employee's Name (Last, first, middle)

ENTER INFORMATION

3. Date of Injury (Mo., day, yr.)

SAME DATE AS ON
 CA-1, CA-2 and CA-2a

4. Occupation

ENTER INFORMATION

5. Description of Injury or Disease:

SHOULD COINCIDE WITH INFORMATION IN BLOCK #14 OF CA-1, BLOCK #15 OF CA-2 OR BLOCK #18 OF CA-2a WHICHEVER IS APPROPRIATE TO THIS CA-16.

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 11, 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 35 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.

1. Furnish office 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 indicated 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.

CHECK APPROPRIATE BLOCK

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official) **ASK SUPPORT PERSONNEL MANAGEMENT OFFICE FOR THIS INFORMATION FOR INJURIES REPORTED ON CA-2. CA-1 INJURIES ARE NOT APPLICABLE.**

8. Signature of Authorizing Official:

SIGNATURE OF SUPERVISOR

9. Name and Title of Authorizing Official: (Type or print clearly)

NAME AND TITLE OF SUPERVISOR

10. Local Employing Agency Telephone Number:

ENTER TELEPHONE NUMBER AT PLACE OF
 TECHNICIAN'S EMPLOYMENT

11. Date (Mo., day, year)

ENTER INFORMATION

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

ENTER ADDRESS IN PARA 4-1 of TPR 810
 R CA-16 SENT TO HOSPITAL. ON CA-16
 TO PHYSICIAN, ENTER ADDRESS OF
 VISOR.

13. Name and Address of Employee's Place of Employment:

Department or Agency **OFFICE OF MILITARY AFFAIRS**
ATTN: NMAG-SPMO
P.O. BOX 4277
 Bureau or Office **SANTA FE, NEW MEXICO 87501**

Local Address (including Zip Code)

ENTER ABOVE INFORMATION IN ALL CASES.

14. Employee's Name (Last, first, middle)

NOTE: DOCTOR OR HOSPITAL MUST COMPLETE THE REMAINDER OF THIS FORM.

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? (If yes, please describe) Yes No

17. What Are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

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)

22. Surgery (if any, describe type) 23. 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(s) of Treatment (Mo., day, year) 28. Date of Discharge From Treatment (Mo., day, year)

30. Is Employee Able to Resume Period of Disability (Mo., day, year) (If termination date unknown, so indicate) Total Disability: From To Partial Disability: From To

Light Work Regular Work Date: 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 Extent of Physical Limitations and the Type of Work That Could Reasonably Be Performed with These Limitations.

33. General 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.

37. Tax Identification Number 38. Date of Report

36. Address (No., Street, City, State, ZIP Code).

Duty Status Report

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



This request for information is authorized by law (5 USC 8101 et seq.). Benefits and/or medical expenses may not be paid or may be subject to suspension under the Federal Employees' Compensation 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 the OMB Cir. A-108.

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS FORM

SUPERVISOR: Complete Part A and refer the form to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. To prevent interruption of the employee's pay, the completed form should be returned to the employing agency (as shown in Item 12) within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in Item 11).

PART A - SUPERVISOR

1. Name and Address of Medical Facility Providing Medical Services: SELF EXPLANATORY	2. OWCP File Number (If known) ENTER OWCP CASE NR	
	3. Employee's Name (Last, first, middle) SELF EXPLANATORY	
	4. Date of Injury (Month, day, yr.) SELF EXPLANATORY	5. Social Security No. SELF EXPLANATORY
	6. Occupation ENTER OFFICIAL TITLE ON JOB DESCRIPTION	

7. Describe How the Injury Occurred and State Parts of the Body Affected.

BE AS SPECIFIC AS POSSIBLE

8. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours. BE AS SPECIFIC AS POSSIBLE SINCE THIS COULD AFFECT LIGHT DUTY ASSIGNMENTS.

Activity	Continuous	Intermittent		Activity/Exposure	Continuous	Intermittent	
a. Lifting/Carrying: Sedentary 0-10 lbs.			Hrs Per Day	d. Fine Manipulation			Hrs Per Day
b. Lifting/Carrying: Light 10-20 lbs.			Hrs Per Day	e. Reaching above Shoulder			Hrs Per Day
c. Lifting/Carrying: Moderate 20-50 lbs.			Hrs Per Day	f. Heat			degrees F
d. Lifting/Carrying: Heavy 50-100 lbs.			Hrs Per Day	g. Cold			degrees F
e. Sitting			Hrs Per Day	h. Excess Humidity			Hrs Per Day
f. Standing			Hrs Per Day	i. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
g. Walking			Hrs Per Day	j. Fumes (Identify)			Hrs Per Day
h. Climbing Stairs			Hrs Per Day	k. Dust (Identify)			Hrs Per Day
i. Climbing Ladders			Hrs Per Day	l. Noise			dBA Hrs Per Day
j. Kneeling			Hrs Per Day	m. Other (Describe)			Hrs Per Day
k. Bending			Hrs Per Day	9. Does the Job Require Driving a Vehicle? SELF EXPLANATORY <input type="checkbox"/> Yes (Specify _____) <input type="checkbox"/> No Operating Machinery? <input type="checkbox"/> Yes (Specify _____) <input type="checkbox"/> No			
l. Stooping			Hrs Per Day	10. The Employee Works SELF EXPLANATORY _____ Hours Per Day _____ Days Per Week			
m. Twisting			Hrs Per Day				
n. Pulling/Pushing			Hrs Per Day				
o. Simple Grasping			Hrs Per Day				

11. Send A Copy of This Report To:

COMPLETE AS SHOWN BELOW
U.S. DEPARTMENT OF LABOR
 Employment Standards Administration
 Office of Workers' Compensation Programs
 525 Griffin Square, Room 100
 Dallas, TX 75202

12. Send The Original Report to (Name and Address of Employing Agency):

Department of Military Affairs
 Attn: NMAG-SP
 PO Box 4277
 Santa Fe, NM 87502-4277

THIS IS THE ONLY NAME AND ADDRESS AUTHORIZED

PART B - PHYSICIAN

13a. Does the History of Injury Given to You by the Employee

Correspond to That Shown in Item 7? Yes No (If not, describe)

13b. Description of Clinical Findings

13c. Diagnosis of Condition Due to Injury

13d. Diagnosis of Other Disabling Conditions

14. Is Employee Able to Perform His/Her Regular Work (Described on the Front of This Form)?

Yes, if so, Full-Time or Part-Time or No, if not, complete item 15 below. (Fill in) Hours Per Day

15. Complete the following if the answer to item 14 is "No".

Activity/Exposure	Continuous	Intermittent	Activity/Exposure	Continuous	Intermittent
a. Lifting/Carrying: Sedentary 0-10 lbs.			d. Fine Manipulation		
b. Lifting/Carrying: Light 10-20 lbs.			e. Reaching Above Shoulder		
c. Lifting/Carrying: Moderate 20-50 lbs.			f. Heat		degrees F
d. Lifting/Carrying: Heavy 50-100 lbs.			g. Cold		degrees F
e. Sitting			h. Excess Humidity		
f. Standing			i. Chemicals, Solvents, etc. (Identify)		
g. Walking			j. Fumes (Identify)		
h. Climbing Stairs			k. Dust (Identify)		
i. Climbing Ladders			l. Noise		
j. Kneeling					
k. Bending					
l. Stooping					
m. Twisting					
n. Pulling/Pushing					
o. Simple Grasping					

Y. Are Interpersonal Relations Affected Because of A Neuropsychiatric Condition? (e.g., Ability to Give or Take Supervision, Meet Deadlines, etc.) Yes (Describe) No

16. Describe Any Other Function of This Employee's Regular Work Which is Medically Restricted By The Injury.

17. Period of Disability (If termination date is unknown, so state) Total Disability From To Partial Disability From To

18. If Employee is Able to Resume Work, Has He/She Been Advised? Yes No If Yes, Give Date of Advice

19. Date of Examination

20. Date of Next Appointment, If Scheduled

I certify that all statements made above are true. I further understand that any knowingly false or misleading statement, or concealment or misrepresentation of material fact may subject me to felony criminal prosecution.

Typed or Printed Name and Address of Physician

22. Specialty

23. Tax Identification Number

24. Physician's Signature

25. Date



ANNEX N

Record of Examination

1. Patient's name Last	First	Middle	2. Date of Injury mo. day yr.	3. OWCP File Number	OMB No. 1215-0155 Expires: 9-30-88
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4. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe)

Yes No

ICD-9 Code

5. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

6. What is your diagnosis?

ICD-9 Code

7. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain answer)

Yes No

8. Did injury require hospitalization? If no, go to item #12 <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Date of admission mo. day yr.	10. Date of discharge mo. day yr.	11. Additional Hospitalization required If Yes, describe in "Remarks" (Item 24) <input type="checkbox"/> Yes <input type="checkbox"/> No
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12. What treatment did you provide?

13. Date of first examination mo. day yr.	14. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	15. Date of discharge from treatment mo. day yr.
--	---	---

16. Period of total disability From mo. day yr. Thru mo. day yr.	17. Period of Partial Disability From mo. day yr. Thru mo. day yr.	18. Date employee able to resume light work mo. day yr.
---	---	--

19. Date employee is able to resume regular work mo. day yr.	20. Has employee been advised that he/she can return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. If yes, on what date was he/she advised? mo. day yr.
---	---	---

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 in item #24 if necessary.)

23. Are any permanent effects expected as a result of this injury? If yes, describe in item #24.
 Yes No

24. Remarks

25. If you have referred the employee to another physician provide the following: Name Address City State Zip	Specialty	26. What was the reason for this referral? <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment
--	-----------	--

Signature

27. 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 felony criminal prosecution.

Signature of Physician _____ Date _____

28. Name of Physician	29. Tax ID Number
City State Zip	30. Do you specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No
	31. If yes, indicate specialty

THIS FORM IS SUBMITTED WITH CA-4 AND CA-7 AND MUST BE COMPLETED BY PHYSICIAN

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-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-31 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 16; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS		ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT	
FOR INSTRUCTIONS SEE REVERSE SIDE			
1. NAME OF INJURED EMPLOYEE (Last, first, middle) ENTER INFORMATION		2. OWCP FILE NUMBER, IF KNOWN ENTER INFORMATION	
3. HOME MAILING ADDRESS (Include zip code) ENTER INFORMATION		4. SOCIAL SECURITY NUMBER ENTER INFORMATION	
5. DATE AND HOUR OF INJURY (Mo., day, year) ENTER INFORMATION <input type="checkbox"/> AM <input type="checkbox"/> PM		6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year) ENTER PERIOD OF LWOP 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT		11. STATE DIAGNOSIS	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, 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 SO ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (Mo., day, year)	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (i.e. lim- itations in stooping, 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		23. DATE OF REPORT (Mo., day, year)	

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

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, CA-20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

1. Complete the entries 7-23 on this report (and items 1-6 if not previously completed by the employing agency), and

2. Forward the report to the OWCP office indicated below:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

PLEASE DO NOT STAPLE IN THIS AREA

NEEDS TO BE SUBMITTED BY ALL PROVIDING MEDICAL CARE EXCEPT HOSPITALS

FORM APPROVED OMB NO 0938-0006

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE (MEDICARE NO.) MEDICAID (MEDICAID NO.) CHAMPUS (SPONSOR'S SSN) CHAMPVA (VA FILE NO.) FECA BLACK LUNG (SSN) OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) 2 PATIENT'S DATE OF BIRTH 3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) 4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 5 PATIENT'S SEX MALE FEMALE 6 INSURED'S ID NO (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS) 7 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER 8 INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO.) 9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER) 10 WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES NO B. ACCIDENT AUTO OTHER 11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) 13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) 15 DATE FIRST CONSULTED YOU FOR THIS CONDITION 16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES 17a IF EMERGENCY CHECK HERE 17 DATE PATIENT ABLE TO RETURN TO WORK 18 DATES OF TOTAL DISABILITY FROM THROUGH 19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY) 20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED 21 AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE) 22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1 2 3 ETC OR DX CODE B EPSDT YES NO FAMILY PLANNING YES NO PRIOR AUTHORIZATION NO 24 A DATE OF SERVICE FROM TO B PLACE OF SERVICE C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN D DIAGNOSIS CODE E CHARGES F DAYS OR UNITS G * T O S H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF 26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO 27 TOTAL CHARGE 28 AMOUNT PAID 29 BALANCE DUE 30 YOUR SOCIAL SECURITY NO 31 PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO 32 YOUR PATIENT'S ACCOUNT NO 33 YOUR EMPLOYER ID NO

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal in-

termediary if this is less than the charge submitted. CHAMPUS is not health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided for items captioned "Insured", i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

although incidental part of a covered physician's service, 3) they may be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For services to be considered a "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral,

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as a claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For

It is mandatory that you tell us if you are being treated for a work-related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER) I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility
- F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation Therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- F - Ambulatory Surgical Center
- H - Hospice
- L - Renal Supplies in the Home
- M - Alternate Payment for Maintenance Dialysis
- N - Kidney Donor
- V - Pneumococcal Vaccine
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery

ANNEX Q

**LIMITED/LIGHT DUTY AND DISABILITY COMPENSATION/LIGHT DUTY
ASSIGNMENT FOR ON-THE-JOB INJURED TECHNICIANS**

1. **LIMITED/LIGHT DUTY FOR ON-THE-JOB INJURED TECHNICIANS:** As a minimum, the following procedures must be used when a technician sustains an on-the-job traumatic disabling injury and elects to use Continuation of Pay (COP).

a. If the treating physician determines that based on the nature of the injury, the technician will not be able to return to work, the supervisor will, prior to the end of the third full day of COP, immediately (personally) furnish a CA Form 17 (Duty Status Report) and a copy of the technician's position description and performance standards to the treating physician. If the on-the-job injury results in immediate surgery, the CA Form 17, position description, and performance standards will be personally hand carried to the physician by the injured technician's first line supervisor after the fifth full day of COP. The CA Form 17 is used to obtain interim medical reports concerning the technician's medical condition and the earliest date the individual will be able to return to work.

b. If the treating physician indicates that the technician is physically able to return to work, the supervisor will notify the individual that he must report for duty at the next scheduled workday. The technician is to be advised that refusing to do so will result in an overpayment and may lead to a disciplinary or adverse action under the provisions of TPR 752. (Technicians refusing to return to duty, although found fit to do so by the attending physician, will be carried in absent without leave (AWOL) status, but authorization to do so must be received from SPMO first.)

c. If the treating physician determines that the technician can perform limited/light duty work, the supervisor will notify the technician that he/she must return to work at the next scheduled workday. Care must be taken to ensure that the duties being performed are in accordance with the restrictions imposed by the physician. Supervisors must contact the SPMO for guidance before returning a technician to limited/light duty.

d. Supervisors must notify the SPMO whenever an injured technician performs military duty (service schools, unit training assemblies, annual training, etc.) while the individual is on COP or compensation. The SPMO is responsible for providing the Office of Workers' Compensation (OWCP) written notification to this effect. OWCP will in most cases offset OWCP benefits received by the amount of military compensation earned. Injured technicians may attend weekend unit training assemblies to earn retirement points only (no pay) and may only perform such duties as to what the attending physician has prescribed.

e. Supervisors must also inform technicians receiving OWCP compensation that should they desire to attend military training and ultimately receive a recurring injury, OWCP may no longer provide medical care or compensation, although they may obtain further medical care through the National Guard (After initiation of a Line of Duty investigation).



f. Limited/light duty for long duration. Should an injured technician remain off duty or in a limited/light duty status for less than 120 days, the supervisor need not initiate any personnel action. However, should an injured technician remain in a limited/light status for 120 days or more, the supervisor must contact the SPMO and request that the position description and performance standards be amended (statement of difference) to indicate the limitations. For instance, a WG-10 aircraft mechanic is injured and is placed in a limited/light duty status as a GS-5 clerk, the technician's position description must be so altered for the period of time the technician is in a limited/light duty status.

2. DISABILITY COMPENSATION/LIGHT DUTY ASSIGNMENT: When a technician loses wages due to an on-the-job injury or illness, he/she is entitled to compensation. Compensation is payable at the rate of $66 \frac{2}{3}$ percent when there are no dependents and 75 percent of salary loss if there are dependents. These benefits are paid until the technician is determined to be no longer disabled by the OWCP or until death. In order to reduce the chargeback cost of compensation claims, the following procedures must be used when a technician files a claim for "OWCP Compensation".

a. When medical evidence shows that an injured technician's disability will continue beyond the 45 days of COP and the technician files for compensation (a claim for compensation must be filed within 3 years of the injury) the supervisor must personally deliver a CA Form 17 to the treating physician to obtain a medical evaluation concerning whether the technician is totally disabled or is medically capable of performing limited/light duties. The supervisor will continue to monitor and provide the physician with a CA Form 17 every two weeks for the duration of the disability.

b. If the physician determines that the technician can perform limited/light duty, the supervisor will immediately contact the SPMO to determine the availability of a position within the commuting area. (The position can either be at the same or lower grade.) If such a position is available, the SPMO will notify the technician and OWCP in writing of the availability of the position and make a job offer to the technician. If the job offer is considered to be suitable by OWCP and the technician refuses the offer, the SPMO will notify OWCP. OWCP will determine whether the refusal is a basis for termination of compensation benefits.

c. If a funded position is not available in the commuting area, the supervisor, in cooperation with the SPMO and the servicing classification activity, will modify the existing position description to reflect the restrictions imposed by the injury if management determines that restructuring the position description will not adversely impact on mission accomplishment. The supervisor, through the SPMO should notify the technician of the availability of the modified position and at the same time notify OWCP. Final determination concerning the suitability of the job offer is the responsibility of OWCP.



d. If the technician accepts the position, the SPMO will notify OWCP at the earliest time possible of the date the technician returned to duty. Compensation benefits will be terminated or adjusted as of the date of return to duty (RTD). To avoid overpayment of compensation, the SPMO should notify OWCP by telephone no later than close of business on the first day of RTD. The telephone notification must be followed up with a CA Form 3 (Report of Termination of Disability and/or Payment).

e. In all cases regarding a job offer, OWCP must be notified. Upon receipt of the job offer, OWCP will promptly evaluate the position to determine whether it is within the medical restrictions imposed by the technician's physician. If determined to be a suitable offer, OWCP will notify the technician and the SPMO in writing that the offer is found to be within the medical restrictions imposed and that the technician is expected to accept the position. Failure to accept the position may result in termination of compensation.

