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

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

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)	2. Social Security Number
DOGOOD, CAN B.	000-00-0000

3. Date of birth Mo. Day Yr.	4. Sex	5. Home telephone	6. Grade as of date of injury
05 02 52	☐ Male ☐ Female	(601) 555-5555	Level 5 Step 8

7. Employee's home mailing address (include city, state, and zip code)
207 Betterhills Drive
Jackson, M-S 39216-1027

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

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
2nd floor, break room, Miss Military Department, Riverside Drive, Jackson, MS 39216-1027

10.Date injury occurred Mo. Day Yr.	Time	11.Date of this notice Mo. Day Yr.	12. Employees Occupation
02 01 87	1000 ☐ a.m. ☐ p.m.	02 01 87	Personnel Clerk

13. Cause of injury (Describe what happened and why)
Pouring coffee at break area when coffeepot exploded and burst. Glass from broken pot cut and burnt both hands.

a. Occupation Code
GS-0203

14. Nature of injury (identify both the injury and the part of body, e.g., fracture of left leg)
cut and burnt left and right hands

b. Type code
420

c. Source code
0840

OWCP Use - NO Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to 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 it 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

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)

Name of witness Signature of witness Date signed

Address City State Zip Code

Official Supervisor's Report: Please complete Information requested below

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code)
Mississippi Military Department, ATTN: HRO-TESS

OWCP Agency Code
3894 HI (Army)
3752 HI (Air)

PO Box 5027

OSHA Site Code

Jackson, MS

Zip Code
39296-5027

18. Employee's duty station (Street address and zip code)
HRO, Miss Military Department, PO Box 5027, Jackson, MS

Zip Code
39296-5027

19. Regular work hours: From 0730 a.m. / p.m. To 1600 a.m. / p.m.

20. Regular work schedule: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

21. Date of injury: Mo. 02 Day 01 Yr. 87

22. Date notice received: Mo. 02 Day 01 Yr. 87

23. Date stopped work: Mo. 02 Day 01 Yr. 87 Time 1005 a.m. / p.m.

24. Date pay stopped: Mo. Day Yr. NA

25. Date 45 day period began: Mo. 02 Day 02 Yr. 87

26. Date returned to work: Mo. 02 Day 04 Yr. 87 Time 0730 a.m. / p.m.

27. Was employee injured in performance of duty? Yes No (if "No," explain)
EMPLOYEE WAS EMPLOYED IN A CIVILIAN STATUS AT TIME OF INJURY

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

29. Was injury caused by third party? Yes No (if "No," go to item 31.)

30. Name and address of third party (include city, state, and zip code)

31. Name and address of physician first providing medical care (include city, state, zip code)
Miss Medical Center
201 North State Street
Jackson, MS 39202

32. First date medical care received: Mo. 02 Day 01 Yr. 87

33. Do medical reports show employee is disabled for work? Yes No
RTW 02-04-87

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

35. Does the employing agency controvert continuation of pay? Yes (If "Yes," explain) No
(See instructions for explanation of "controvert")

36. Pay rate when employee stopped work
$ 8.76 Per hour

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:

Name of supervisor (Type or print)
John K. Knowall

Signature of supervisor Date 02-01-87

Supervisor's Title Supv Pers Mgmt Spec Office Phone 601-949-6337

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

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

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related, traumatic injuries:

Continuation of pay for disability resulting from traumatic, job-relayed injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filled within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation pay.)

(2) Payment of compensation for wages loss after the 45 days, if disability extends beyond such period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, ect.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be Interrupted until:

(1) The employing agency receives medical information from the attending physician to the effect that disability has terminated; or

(2) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filled with OWCP. To avoid interruption of income, the form should be filled on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45-day period expires.

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

Privacy Act

In accordance with the Privacy Act of 1074 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that:

(1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the office receives and maintains personal information on claimants and their immediate families.

(2) The information will be used to determine eligibility for and the amount of benefits payable under the Act.

(3) The information may be used by other agencies or persons in matters relating directly or indirectly to the matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or complied with the provisions of 20 CFR 10.

(4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by (Name of injured employee)	SELF-
Which occurred on (Mo., Day, Yr.)	
At (Location)	
Signature of Official Superior late Date (Mo., Day, Yr.)	

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form, which may require further clarification, are explained below.

Employee (Or person acting on the employee's behalf)

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

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

15) Election of COP/Leave
If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you later change your election, the agency is not obligated to convert past periods of leave to COP.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within two working days after it is received.

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

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

17) Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code
The address and zip code of the establishment where the employee actually works.

29) Was injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

31) Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32) First date medical care received
The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?
COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability results from an occupational disease or illness;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is neither a citizen nor a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

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

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

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work-Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code). OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record keeping and Reporting Guidelines.

OWCP Agency Code
This Is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Notice of Occupational Disease
and Claim for Compensation

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

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a. b. and c.

Employee Data

1. Name of employee (Last, First, Middle)	2. Social Security Number
ALLRIGHT, JIM D.	000-00-0011

3. Date of birth Mo. Day Yr.	4. Sex	5. Home telephone	6. Grade as of date of last exposure
12 05 46	M	(601) 122-1222	Level 10 Step 05

7. Employee's home mailing address (Include city, state, and zip code)	8. Dependents
2009 Overthere Somewhere, MS Zip Code 39401-2009	Wife, Husband Children under 18 years Other

Claim Information

9. Employee's occupation	a. Occupation Code
Hvy Mob Eqp Mech	

10. Location (address) where you worked when disease or illness occurred (Include city, state, and zip code)	11. Date you first became aware of disease or illness Mo. Day Yr.
MATES, New MATES Building Cp Shelby, MS 39407-5500	02 01 87

12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr.	13. Explain the relationship to your employment, and why you came to this realization
03 01 87	Occupational Health Nurse did hearing screening and found a loss of hearing in both ears. In her findings, and because of the loudness of the equipment in our work area, has either caused or aggravated this hearing loss.

14. Nature of disease or Illness	OWCP Use - Not Code	
	b. Type code	c. Source code
Hearing Loss	620	0240

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
I did not realize the degree and seriousness of this hearing loss, and that it was possibly work related claim.

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

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

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 03-01-87_____
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

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and zip code)
Miss Military Department, ATTN: HRO-TESS

OWCP Agency Code
3894 HI (Army)
3752 HI (Air)

PO Box 5027

OSHA Site Code

Jackson, MS

Zip Code
39296-5027

20. Employee's duty station (Street address and zip code)
MATES, New MATES Building, Cp Shelby, MS

Zip Code
39407-5500

21. Regular work hours From : 0730 a.m. p.m. To 1600 : a.m. p.m.

22. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

23. Name and address of physician first providing medical care (include city, state, zip code)
Dr. Joseph J. Gogetter

2000 Hardy Street

Hattiesburg, MS 39401

24. First date medical care received Mo. 03 Day 01 Yr. 87

25. Do medical reports show employee is disabled for work? Yes No

26. Date employee first reported condition to supervisor Mo. 03 Day 01 Yr. 87

27. Date and hour employee stopped work Mo. Day Yr. Time : a.m. p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time : a.m. p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time : a.m. p.m. NA

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

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)

Signature of Supervisor

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

Name of Supervisor (Type or print)
Hugo Adams

Signature of Supervisor
(original)

Date
03-01-87

Supervisor's Title
HVY MOB EQP MECH FMN

Office phone
Amex H 10-H-2 601-583-9213

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

NOTICE OF EMPLOYEE'S RECURRENCE OF DISABILITY AND CLAIM FOR PAYICOMPENSATION

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

PART A - EMPLOYER

1. NAME OF INJURED EMPLOYEE *(last, first, middle)*	2. SOCIAL SECURITY NUMBER	3. OWCP file number for original injury *(if known)*

4. HOME MAILING ADDRESS (include zip code)	5. HOME TELEPHONE Area Code Number

6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury (*number, street, city, state, zip code)*	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6.

8. DATE AND HOUR of original injury *(Mo., day, year)*	9. DATE AND HOUR of recurrence *(mo., day, year)* a.m. p.m.	10.DATE AND HOUR stopped work following recurrence *(Mo., day, year)* a.m. p.m.	11. DATE AND HOUR pay stopped following recurrence *(Mo., day, year)* a.m. p.m.

12. PAY RATE IN EFFECT ON: A. Date of Recurrence B. Date Stopped Work Following Recurrence	a. Base pay	b. Subsistence	c. Quarters	d. Other pay
	$ per $ per	$ per $ per	$ per $ per	$ per $ per

13. Show workweek at time pay stopped, if other than Monday thru Friday S M T W T F S	14. DATE.AND HOUR returned to work, following recurrence (mo., *day, year)* am. p.m.	15. At time of recurrence did official superior authorize medical treatment? YES NO

16.DATE employee first received medical treatment following recurrence *(Mo., day, year)*	17. NAME AND ADDRESS of physician treating employee following recurrence

18.	SELF-EXPLANATORY- FOLLOW INSTRUCTIONS IN ANNEX E, Page 10-E-2	forming his/her

19. Describe the circumstance 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.

20. Signature of official superior *(at time of recurrence)*	21. Title	22. Official superior's work phone number	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. *(Mo., day, year)* From: Through:	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.).*	27. 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

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

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

Period: From: Through:

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).*

Period: From: Through:

c. Continuing compensation on account of occupational disease.

Period: From: Through:

30. Signature of Employee or Person Acting on his/her Behalf	31. Date *(Month, day, year)*

INSTRUCTIONS FOR COMPLETING FORM CA-2a
RECURRENCE OF DISABILITY

DEFINITION OF RECURRENCE

When after returning to work, an injured employee is again disabled and stops work as a result of the original injury or occupational disease, such disability is considered by the Office of Workers' Compensation Programs (OWCP) to be a recurrence. In these instances Form CA-2a is required. If a new incident occurs, the matter should be treated as a new injury and Form CA-1 (traumatic injury) or Form CA-2 (occupational disease) submitted accordingly.

INSTRUCTIONS

* Form CA-2a is used to report an employee's recurrence(s) of disability for traumatic injury and/or occupational disease. Part A must be completed by the employing agency in every case. Part B must be completed by the employing agency in traumatic injury cases only. Part C must be completed by the employee or someone acting on his/her behalf.

* Form CA-2a should be submitted promptly by the employing agency upon receiving notice that the employee has suffered a recurrence.

* If the original injury was not previously reported to OWCP, a report specifically covering the original injury should be made on Form CA-1 (traumatic injury) or CA-2 (occupational disease) and attached when Form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.

* If this is a recurrence of an occupational disease, the employee may claim wage loss on Form CA-4 if this form was not submitted following original injury. If Form CA-4 was previously submitted, compensation beyond the date Form CA-2a is signed, may be claimed on Form CA-8.

* If this is a recurrence of a traumatic injury, and the 45 Continuation of Pay (COP) days have been exhausted, the employee may claim wage loss beyond the date Form CA-2a is signed on Form CA-7. If Form CA-7 has been filed previously, wage loss beyond the date Form CA-2a is signed may be a claimed on Form CA-8. The OWCP will be responsible for payment of compensation if the claim is approved.

* Where pay is continued, the employing agency should obtain medical evidence on Form CA-17, "Duty Status Report", as often as circumstances indicate.

* If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Report of Termination of Disability and/or Payment, should be forwarded when the employee returns to work.

* If the recurrence happens less than six months following the most recent prior medical treatment received by the employee, the supervisor shall authorize required medical care by use of Form CA-16. If the recurrence happens more than six months after the most recent prior medical care, authorization for further medical care must be obtained from the OWCP.

* When the employee has received medical care as a result of the recurrence, a detailed medical report should be submitted by the attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between employee's condition and the original injury.

* If the employee was treated by other physicians after returning to work following the original injury, similar medical reports should be obtained from each.

* If the recurrence happened six months or more after the employee returned to duty following the original injury, A STATEMENT FROM THE EMPLOYEE MUST ACCOMPANY FORM CA-2a. The statement should describe the employee's duties upon his/her return to work, state whether he/she had any other injuries or illness and give a general description of his/her physical condition during the intervening period. The employee should explain why he/she believes the present condition is related to the original injury.

* If this a recurrence of a traumatic injury, the injured employee is entitled to COP if:

* the 45 calendar days were not all used, and

* this period of COP is during a six month period beginning from the date the employee first returned to work following initial disability, and

* the employee elects to receive COP in lieu of sick or annual leave.

* If the employing agency has any information which would show that the employee's benefits should not continue, this information should be submitted with Form CA-2a.

* When the employee is not able to return to the same duties and suffers pay loss as a result of this disability, he/she may be entitled to additional compensation based on loss of wages, or loss of wage-earning capacity. Upon notification of such loss, OWCP will advise the employee of the procedure to follow to claim additional compensation.

* U.S. G.P.O. 1982-564-036/0390

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

REPORT OF TERMINATION OF DISABILITY AND/OR PAYMENT

PART - A GEPJERAL

1. Name of Injured Employee *(last, first, middle)*	2. Social Security Number	3. OWCP File Number *(if known)*
DOGOOD, CAN B.	00 0-00-0000	

4. Department or Agency	5. Bureau or Office
DA, TAG-MS	MS Mil Dept, HRO, Jackson, MS

6. Name and Address of Reporting Office *(Include Zip Code)*
MS Mil Dept, HRO
PO Box 5027, Jackson, MS 39296-5027

7. Date and Hour of Injury *(Mo., day, year)*	8. Date and Hour Stopped Work (Mo., *day, year)*	9. Date and Hour Pay Stopped (Mo., *day, year)*	10. Date and Hour Returned to Work *(Mo., day, year)*
02-01-87 1000 AM PM	02-01-87 1005 AM PM	NA AM PM	0730 AM 02-04-87 PM

11. Employee's Workweek On Return To Duty If Other Than Monday Thru Friday	12. Present Pa Rate If Different From That Received At Time Employee Stopped Work.			
	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
S M T W T F S				

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*
From: Through:	From: Through:	From: Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?
Yes No If Yes, Describe The Type of Work Employee Is Performing.

15. If Interrupted, Show Dates Deductions For Health Benefits and/or Option Insurance Were Resumed *(Mo., day, year)*	16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change *(Mo., day, year)*
Health Benefit Optional Insurance	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 *(Mo., dry, year)*	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.
From: 02-02-87 Through: 02-03-87	$8.76 ph $140.16

20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change *(Mo., day, year)*	21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New			
	a. Base Pav	b. Subsistence	c. Quarter	d. Other *(Specify)*

22. Signature of Supervisor	23. Title and Office Phone Number	24. Date *(Mo., day, year)*
	Supv Pers Mgrnt Spec 601-949-6337	02-04-87

Form CA-3
Rev. Dec. 1974

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

PART - A

REQUIRED WRITTEN REPORT	When disability ceases and/or employee returns to work, the official superior shall immediately report 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.
TELEPHONE/ TELEGRAPH REPORT	If the employee is receiving disability compensation periodically each four weeks, the official superior should immediately telephone or telegraph the OWCP advising the date employee returned to work This will avoid an overpayment of compensation. Follow-up should then be made with Form CA-3.
PAY RATE INFORMATION	Employees base pay in items 12a or 21a should not include value of subsistence, quarter or other pay. These should be-shown separately in their own columns.

PART - B

CONTINUATION OF PAY	In most traumatic injury cases, the employee will have 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.

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 Federal Employees' Compensation	CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

1. NAME OF DECEASED EMPLOYEE *(Last. first, middle)*	2. DATE OF BIRTH (Mo., day, year)	3. DATE OF INJURY (Mo., day, year)	4. DATE OF DEATH (Mo., day, year)	5. SOCIAL SECURITY NUMBER

6. NAME AND ADDRESS OF EMPLOYING AGENCY *(Include Zip Code)*	7. NATURE OF INJURY WHICH CAUSED DEATH

CLAIM OF SURVIVING HUSBAND OR WIFE (Items 8 through 13)	8. NAME AND ADDRESS *(Include Zip Code)*	9. YOUR DATE OF BIRTH (Mo., day, year)	10. DATE OF MARRIAGE TO EMPLOYEE (Mo., day, year)

11. WHERE YOU LIVING WITH THE EMPLOYEE AT TIME OF DEATH? YES NO	12. WERE YOU EVER MARRIED TO ANYONE OTHER THAN THE EMPLOYEE? YES NO	13. WAS EMPLOYEE EVER MARRIED TO ANYONE OTHER THAN YOURSELF? YES NO

14. LIST ALL OF EMPLOYEE'S CHILDREN FROM THIS MARRIAGE WHO MAY BE ENTITLED TO COMPENSATION *(See attached information sheet for definition of children)*

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS *(include zip code)*

SELF-EXPLANATORY. FOLLOW INSTRUCTIONS IN ANNEX E, Page 10-E-3.

14a. LIST ALL

de zip code)

15. IF A LEGAL GUARDIAN HAS BEEN APPOINTED FOR ANY CHILD NAMED ABOVE, GIVE NAME OF CHILD, NAME AND ADDRESS OF THE GUARDIAN.

CHILD	GUARDIAN	GUARDIAN'S ADDRESS (Include *Zip Code)*

16. LIST OTHER RELATIVES WHO WERE FULLY OR PARTIALLY DEPENDENT ON EMPLOYEE:

NAME	RELATIONSHIP	DATE OF BIRTH	ADDRESS (Include Zip *Code)*

17. IF EMPLOYEE WAS EVER IN THE ARMED FORCES OF THE UNITED STATES, GIVE: SERVICE NUMBER: BRANCH OF SERVICE: PERIOD OF SERVICE:	18. IF APPLICATION HAS BEEN MADE FOR VETERANS ADM INISTRATION (VA) BENEFITS BECAUSE OF EMPLOYEE'S DEATH GIVE: VA CLAIM NUMBER: ADDRESS OF VA OFFICE WHERE CLAIM IS FILLED:
19. IF APPLICATION HAS BEEN MADE FOR U.S. CIVIL SERVICE ANNUITY BECAUSE OF EMPLOYEE'S DEATH, GIVE: CSC CLAIM NUMBER: DATE ANNUITY BEGAN: AMOUNT PAID PER MONTH: $_____	20. IF CLAIM HAS BEEN MADE AGAINST A THIRD PARTY BECAUSE OF EMPLOYEE'S DEATH, GIVE: AMOUNT OF RECOVERY: $_____ NAME AND ADDRESS OF THIRD PARTY:

21. TOTAL BURIAL EXPENSE $_____	22. AMOUNT OF BURIAL EXPENSE PAID OR PAYABLE BY VA	23. NAME AND ADDRESS OF PARTY *(Other than VA)* WHOSE FUNDS WERE USED TO PAY BURIAL EXPENSE AND AMOUNT PAID: $_____

I HEREBY CERTIFY THAT EACH AND EVERY STATEMENT MADE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

24. SIGNATURE OF PERSON FILING CLAIM	25. ADDRESS *(Include Zip Code)*	26. DATE *(Mo., day, year)*

CA5

INSTRUCTIONS FOR COMPLETING FORM CA-5, CLAIM FOR COMPENSATION BY WIDOW, WIDOWER, AND/OR CHILDREN

Who Should File Claim	This claim form should be completed and filed by the widow or widower for self and surviving children. If there is no surviving widow or widower, the children's guardian completes the claim.
When Should Claim be Filed	Claim must be filed within one year following the date of death.
What Documents are Required	The marriage certificates for a widow or widower; death certificate for decedent if not previously submitted; birth certificate or adoption documents for each child. Also if appropriate, Letters of Guardianship. If either the decedent or the surviving spouse was previously married, legal documents showing dissolution of such prior marriage(s). Copies of certificates or documents are acceptable only ' if they are certified by the person having official custody of such records. They should then be attached to the claim when it is filed.
How to Complete Claim	All items should be completed. If an item is not applicable, indicate by showing "NA". Note that the form requests information about several different categories of persons, i.e., items 1-7 make inquiry about the decedent; 8-13 the surviving widow or widower; 14-14a surviving children; and 15, the children's guardian. The attending physician's report on the reverse of the claim must also be completed before the form is submitted to the OFEC.
Funeral/Burial Allowance	Submit original itemized funeral and burial bills. If paid, so indicate and give name and address of person making payment. If an Administrator or Executor has been appointed, give his name, address and attach a copy of the appointment document.

See the reverse of this page for a definition of dependents and a description of benefits.

Form CA-5
REV. JULY 1973

Amex K 10-K-2

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs	OFFICIAL SUPERIOR'S REPORT OF EMPLOYEE'S DEATH

1. Name of Deceased Employee *(Lost. first, middle)*	2. Date of Birth *(Mo., day, year)*	3. Male Female	4. Social Security Number

5. Department or Agency (DUTY STATION ZIP CODE)	6. Bureau or Office (OWCP AGENCY CODE)

7. Name and Address of Reporting Office	8. Name and Office Phone Number of Employee's Official Superior

9. Date and Hour of Injury (Mo., day, year) AM PM	10. Date and Hour of Death (Mo., day, year) AM PM	11. Date and Hour Employee's Pay Stopped (Mo., day, year) AM PM

12. Describe How Injury Occurred (TYPE CODE) (SOURCE CODE)	13. Was Employee in Performance of Duty When Injury Occurred? Yes No (If No, Explain): (OCCUPATION CODE)

14. Location Where Injury Occurred	15. Location Where Death Occurred	16. Immediate Cause of Death *(Attach Medical and Autopsy Reports if Available)*

17. Employee's Pay Rate As Of	a. Base Pay	b. Subsistence	c. Quarters	d. Other
A. Date of Injury	$ per	$ per	$ per	$ per
B. Date Pay Stopped	$ per	$ per	$ per	$ per
	$ per	$ per	$ per	$ per

18. Did Empl for a Full Ele	SELF-EXPLANATORY. SUPERVISOR'S REPORT OF DEATH.	employment
20. Did Empl --- a. Ann ---		--- ---

21. Did Employee Receive Continuation of Pay (COP) During Period Prior to Death?

a. Pay Rate Used For COP $ per	b. Inclusive Dates of COP From To	c. Gross Dollar Amount of COP $ per

22. If Employee was Enrolled in Health Benefit Plan for Self and Family, Show HBS Code Number:	23. Show Date Through Which HBS Deductions Were Last Made (Mo., day, year)	24. If Employee Received Medical Care Prior to Death, Give Name and Address of Attending Physician

25. If Injury was Caused by a Third Party, Give Name and Address of Third Party	26. Give Name and Address of the Attorney Representing the Survivors if Legal Action is Instituted Against the Third Party	27. Show Amount of Third Party Recovery, If Any $

28. If Employee was a Member of the Armed Services of the United States, Show: Branch of Service: Serial No. (if known)	29. Has a Claim for Survivor's Benefit Been Filed with the United States Civil Service Commission? Yes No

30. Name and Address of Employee's Spouse or Next of Kin *(Show relationship, if other than spouse)*

31. Signature of 0fficial Superior	32. Title	33. Date *(Mo., day, year)*

Form CA-6
Rev. July 1976

INSTRUCTIONS FOR COMPLETING FORM CA-6

When a Federal employee dies as a result of injury in performance of duty or because of an employment-related disease, the death should be reported on this form. This form eliminates the need to complete and file the official superior's report on Form CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation. It also replaces the "Report of Death" on Form CA-3 (Dec. 1970 version).

The form is to be completed by the deceased employee's official superior or other authorized official of the employing agency. It should be accompanied by a certified copy of the death certificate when submitted to the OWCP.

If additional space is required, attach separate sheets numbering the answers to correspond with the items on the form.

For additional information about death benefits, see 20 CFR 1.1 and/or Chapter 810, Injury Compensation, Federal Personnel Manual.

U. S. GOVERNMENT PRINTING OFFICE: 1982-361-646

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Stock No. 029-016-00039-9

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs (OWCP)	**CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY**

PART A - EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*	2. Social Security Number	3. OWCP FLIE Number (if known)

4. Is Claim Being Made For Wage Loss? Yes No	5. Is Claim Being Made For Scheduled Award Based on Permanent Disability Involving Member, Organ Or Function of Body? Yes No
6. Period Compensation is Claimed As A Result Of Wage Loss *(Mo., day, year)* From: _____ Through: _____	7. Has Any Pay Been Received For The Period Shown In Item 6? Yes No If Yes State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)* $_____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? Yes No If Yes, Give Name And Address Of Such Party Or Insurance Carrier	9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? Yes No If Yes, Furnish	a. Service Number	b. Branch Of Service	c. Period Of Service *(Mo., day, year)* From: _____ Through: _____

11. If Answer To Item 10 is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? Yes No If Yes, Furnish	a. Claim Number	b. Address of VA Office Where Claim Is Filed	c. Nature Of Disability And Monthly Payment $ _____

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? Yes No If Yes, Furnish	a. Claim Number	b. Date Annuity Began *(Mo., day, year)*	c. Amount of Monthly Payment $ _____

13. List Your Dependents Living With You?

Name	Relationship	Date of Birth	*(Yes/No)*	Mailing Address, If Different From Your Own

SELF-EXPLANATORY. FOLLOW INSTRUCTIONS IN ANNEX E, Page 10-E-3

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' and Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

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 bemuse 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.

15. Employee's Signature	16. Employee's Home Mailing Address (Include *Zip Code)*	17. Date *(Mo., day, year)*

Form CA-7
Feb. 1975

Amex M 10-M-1

STATEMENT OF OFFICIAL SUPERIOR

PARTB - GENERAL

18. Name and Address of Reporting Office *(Number,* street, city, *state, zip code)*

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify) MILITARY
Date of Injury	$ per	$ per	$ per	$ per
Date Employee Stopped Work				

20. If Employee Received Additional Pay, i.e., .Premium, Sunday, Night Differential. Identify Type And Show Amount	21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
TYPE $ PER	S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?	23. If Answer To 22 Is No. Would The Position Have Provided Employment For Eleven Months, Except For The Injury?	24. Total Length of Employee's Federal Civilian Service
Yes No	Yes No	

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other (Specify)

PART C - CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes	27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave	28. Gross Dollar Amount of Regular Pay, Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$_____ per _____	From:_____ Through:_____	$_____

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)
	$ per	$ per	$ per	$ per

PART D - COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*	31. Period For Which Compensation Is Claimed
AM PM	From: _____ Through: _____

32. Deductions:

	Health Benefits		Optional Insurance	
a. Was Employee Enrolled On Date Pay Stopped?	Yes	No	Yes	No

b. It Yes, Furnish Code Number.
c. It Yes Give Date Through Which Deductions Were Last Made.

PART E - RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*	34. Pay Rate At Time Returned To Work	35. Show Work Week On Return To Work If Other Than Monday Through Friday
AM PM	$_____ per_____	S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F - CERTIFICATION

37. 1 certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*

CA-7
REV. Feb. 1975

Amex M

10-M-2

Claim For Continuing Compensation On Account Of Disability

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

STATEMENT OF INJURED EMPLOYEE - SEE INSTRUCTIONS ON REVERSE SIDE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)* (SUBMIT EACH PAY PERIOD UNTIL OWCP PICKS UP ON PERMANENT ROLLS)	2. OWCP FILE NUMBER, IF KNOWN
3. HOME MAILING ADDRESS *(Include ZIP code)*	4. Social Security Number

5. DATE AND HOUR OF INJURY *(Mo., day, year)* AM PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)*. IF PAY LOSS WAS INTERMITTENT ATTACH SEPARATE SHEET SHOWING DATES AND HOURS OF PAY LOSS. FROM: THROUGH:
7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6? YES NO SHOW INCLUSIVE DATES. FROM: THROUGH: IF LEAVE USE WAS INTERMITTENT, ATTACH SEPARATE SHEET SHOWING DATES AND HOURS USED.	8. DO YOU WISH TO REPURCHASE LEAVE? YES NO

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6. ATTACH A SEPARATE SHEET IF NEEDED.

a. SALARI ED EMPLOYMENT

DATES & HOURS WORKED	PAY RATE (Per hour, day or week)	TOTAL AMOUNT EARNED	TYPE WORK PERFORMED	NAME & ADDRESS OF EMPLOYER

b. COMMISSION AND SELF-EMPLOYMENT *SHOW ALL ACTIVITIES WHETHER OR NOT INCOME RESULTED FROM YOUR EFFORTS.*

DATES & HOURS WORKED	NAME AND ADDRESS OF BUSINESS	SELF-EMPLOYED COMMISSION	TYPE OF ACTVITY PERFORMED	INCOME DERIVED (ATTACH EXPLANATION IF NEEDED)

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION

SELF-EXPLANATORY. FOLLOW INSTRUCTIONS IN ANNEX E, Page 10-E-3

11. IF YOU WER

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:

CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

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

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYJEE'S BEHALF. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to maintain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.	15. DATE *(Mo., day, year)*

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)* AM PM	17. SHOW EMPLOYEE'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 REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6 ON THE REVERSE SIDE? YES NO	19. IF ANSWER TO ITEM 18 IS YES, SHOW: AMOUNT: $_____ TYPE OF PAYMENT: PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show, amount and period.)*

21. REMARKS

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

INSTRUCTIONS FOR INJURED EMPLOYEE

a. 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.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise, notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16 through 24 and forward the form to the appropriate OWCP office.

b. 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: FAILURE TO SUBMIT THIS FORM PROPERLY COMPLETED WITH SUPPORTING MEDICAL EVIDENCE WILL DELAY PAYMENT OF COMPENSATION.

Authorization For Examination and/or Treatment

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

The following request for Information is authorized by law (5 USC 8101 et. seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under 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:

2. Employee's Name *(Last, first, middle)*	3. Date of Injury *(Mo., day, yr.)*	4. Occupation

5. Description of Injury or Disease:

6. You are
condition s

A. Your sig
OWCP and

B. 1. F

2. T
th

SELF-EXPLANATORY. FOLLOW INSTRUCTIONS IN
ANNEX E, Page 10-E-4

11, subject to the

allowable fee established by

r than emergency must have

ty, or is otherwise related to
promptly advise the
Pending further
t.

7. If a Dise
Authorizati
Official)

e or print clearly)

10. Local Employing Agency Telephone Number:	11. Date *(Mo., day, year)*
12. Send one copy of your report: *(Fill in remainder of address)* Mississippi Military Department ATTN: SPM-TES PO BOX 5027 Jackson, MS 39296-0527	13. Name and Address of Employee's Place of Employment: Department or Agency Bureau or Office Local Address *(including Zip Code)*

Form CA-16
(Rev. 6/84)

PART B - ATTENDING PHYSICIAN'S REPORT

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

15. What History of Injury or Disease Did Employee Give You?

16. Is There Any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? *(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)*

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 Date:
Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She Been Advised? Yes No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate The 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

MEDICALBILL: Charges for your services should be presented on the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

INSTRUCTIONS TO AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standard billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA- 1 6.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL

U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which requires medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item 8. Check Box B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box 82 may be checked.

Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

See 20 CFR 1 and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician - See Reverse Side

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION	Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60-day period, apply to the office shown in Part A, Item 12.
USE OF CONSULTANTS AND HOSPITALS	You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.
REPORTS	After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17, "Duty Status Report" may be required by the employing agency during tire first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.
RELEASE OF RECORDS	Injury reports are the official records of OWCP. They shall not be released to to anyone nor may any other use be made of them without the approval of OWCP.
BILLING FOR SERVICES	OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form by the applicable Current Procedural Terminology (4th edition) Code (CPT4). A copy of the form may be supplied by the employee at the time treatment is sought. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.
TAX IDENTIFICATION NUMBER	The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.
ADDITIONAL INFORMATION	Contact the OWCP Office shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs (OWCP)	DUTY STATUS REPORT

PART A -SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

2. EMPLOYEES NAME *(Last, first, middle)*	3. DATE OF INJURY *(Mo., day, year)*	4. OCCUPATION	5. SOCIAL SECURITY NUMBER

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT_____ COLD_____ NOISE_____ DUST_____
FUMES_____ STRESS_____ OTHER_____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

		OFTEN
SEDENTARY - LIF	SELF-EXPLANATORY. FOLLOW INSTRUCTIONS IN ANNEX E, Page 10-E-4	
LIGHT - LIFTING		
MODERATE - LIF		
HEAVY - LIFTING		
PULLING/PUSHIN		
REACHING OR W		
WALKING		
STANDING		

8. SEND A COPY OF THIS REPORT TO:	9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1979

PART 8 - PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HISIHER REGULAR WORK *(Described in Item 7)*? YES NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)
PART TIME FULL TIME *Date (Mo., day, year)*
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGKT WORK? NO YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY (Including Preexisting Conditions).

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY - LIFTING 0 to 10 POUNDS			
LIGHT - LIFTING 10 to 20 POUNDS			
MODERATE - LIFTING 20 to 50 POUNDS			
HEAVY - LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS (Specify):			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(if termination date unknown, so indicate)*
TOTAL DISABILITY FROM TO
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK
REGULAR WORK

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? YES NO, IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

20. PROFESSIONAL DEGREE

21. DATE *(Mo., day, year)*

U.S. Printing Office: 1985-461-033/38749

For sale by the Superintendent of Documents, U.S. Government Printing Office. Washington, D.C. 20402

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*	2. HOME MAILING ADDRESS *(Number, street, city, state, zip code)*
3. DATE AND HOUR OF INJURY *(Mo., day, year)* ☐ AM ☐ PM	4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* FROM TO
5. WHAT HISTORY OF INJURY *(including disease caused by the employment)* DID EMPLOYEE GIVE YOU?	
6. WHAT ARE YOUR FINDINGS *(Include results of x-rays, laboratory tests, etc)*?	
7. WHAT IS YOUR DIAGNOSIS?	
8. DO YOU BELIEVE THIS DISABILITY IS IN ANYWAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? *(Please explain* your answer *if there are doubts)* ☐ YES ☐ NO	
9. DID INJURY REQUIRE HOSPITALIZATION? ☐ YES ☐ NO IF YES, DATE OF ADMISSION *(Mo., day, year)* DATE OF DISCHARGE	10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☐ NO
11. OPERAT	ED
13. WHAT (	IF ANY.
15. DATE O EXAMINAT *(Mo., day, ye*	CHARGE TEMENT *)*
18. PERIOD OF DISABILITY (If termination date unknown so indicate) *(Mo., day, year)* TOTAL DISABILITY: FROM TO PARTIAL DISABILITY: FROM TO	19. DATE EMPLOYEE ABLE TO RESUME *(Mo., day, year)* LIGHT WORK REGULAR WORK
20. IF EMPLOYEE IS ABLE TO RESUME WORK. HAS HE BEEN ADVISED? ☐ YES ☐ NO IF YES. FURNISH DATE ADVISED.	
2l. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.	
22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.	

23. SIGNATURE OF PHYSICIAN	24. ADDRESS *(Number, street, city, state, zip code)*	25. DATE OF REPORT *(Mo., day, year)*

SELF-EXPLANATORY. TO BE SUBMITTED WITH CA-7.

CA-20
Rev. Feb. 1975

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.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 5-25 ON THE FORM (AND ITEMS 1-4 IF NOT COMPLETED PREVIOUSLY); AND

2. IF DISABILITY HAS NOT TERMINATED INDICATE IN ITEM 18; AND

3. FORWARD THIS REPORT TO THE OWCP OFFICE INDICATED BELOW:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

U.S. GOVERNMENT PRINTING OFFICE: 1979 0-295-726

For sale by Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402
Stock Number 029-016-00030-5

OMB No. 1215-0103
Expires: 09/30/86

Attending Physician's Supplemental Report

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

FOR INSTRUCTIONS SEE REVERSE SIDE

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

5. DATE AND HOUR OF INJURY *(Mo., day, year)* ☐ AM ☐ PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)* FROM: THROUGH:	
7. DATE OF MOST RECENT EXAMINATION *(Mo., day, year)*	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? ☐ YES ☐ NO	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? ☐ YES ☐ NO
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	11. STATE DIAGNOSIS	
12. WHAT TREATMENT IS EMPLOYEE RECEIVING AND HOW OFTEN IS IT GIVEN?		
13. WHA[illegible] SELF - EXPLANATORY. TO BE SUBMITTED WITH CA-8.		DISABILITY EMPLOYEE HAS THIS INJURY
15. WILL DISABILITY FOR REGULAR WORK CONTINUE FOR 90 DAYS OR LONGER? YES NO IF N0, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? *(Mo., day, year)*	16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN ADVISED? YES NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED *(Mo., day, year)*	
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. *(i.e. limitations 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. I certify that the statements on the reverse apply to this report and are made a part hereof.	23. DATE OF REPORT *(Mo., day, year)*	

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACTS, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA-20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED. NOT SUBMIT THIS FORM CA-20a.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA-1500/OWCP 1500a.

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

2. Forward the report directly by mail to the OWCP office indicated below.

3.

OFFICE OF WORKERS' COMPENSATION PROGRAMS

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The Information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

*U.S. GPO: 1984-0-421-271/11155

Amex R 10-R-2

PLEASE DO NOT

RETURN TO: Miss Military Department, ATTN: MS-HRO
PO Box 5027, Jackson, MS 39296-5027

STAPLE IN
THIS AREA

FORM APPROVED
OMB NO. 0938-0008

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 INITAL)	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) TELEPHONE NO.	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. INSURED'S ID NO (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS) 8. INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO.) ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICY HOLDER 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) TELEPHONE NO. 11.a. CHAMPUS SPONSORS STATUS ACTIVE DUTY ☐ DECEASED RETIRED ☐ BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW SIGNED DATE		13. I AUTHORIZE PAYMENT OF MEDICAL OF BENFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN 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	16.a. IF EMERGENCY CHECK HERE
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM		DATES OF PARTIAL DISABILITY TROUGH	
19. NAME OF REFERRING PHYSICIAN OR O			STALIZATION GIVE DISCHARGED	
21. NAME AND ADDRESS OF FACILTY WHE			ED OUTSIDE YOUR OFFICE?	
23. A DIAGNOSIS OR NATURE OF ILLNESS ETC. OR DX CODE 1. 2. 3. 4.			G ☐ YES ☐ NO G ☐ YES ☐ NO PRIOR AUTHORIZATION NO.	

PHYSICIAN HAS TO COMPLETE THIS FORM TO BE REIMBURSED FOR HIS SEVICES.

24. A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PRODUCT CODE IDEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	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) (I 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
DATE:	30.YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS ZIP CODE AND TELEPHONE NO.		
32. YOUR PATIENTS ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	I.D. NO.		

PLACE OF SERVICE AND TYPE OF SERVICE (T.0 S.) CODES ON THE BACK
REMARKS:

APPROVED BY
ON MEDICAL SERVICE

Form HCFA-1500 SC (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

Annex S

10-S-1

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature request 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 intermediary it charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniform Services. Information on the patient's sponsor should be provided in 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.

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

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees of 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 8 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.

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.

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

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 amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number would delay payment of the claim.

It is mandatory that you tell us it 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 - (0)	-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 Location
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

TO BE COMPLETED EACH PAY PERIOD

ADMINISTRATIVE LEAVE FOR TRAUMATIC INJURY (CONTINUATION OF PAY - COP)		
PART A - To Be Completed By Supervisor		
1. Name of Injured Technician: (Last, first, middle)		
2. Social Security Number:	3. Date of Injury:	
4. Organization/Activity:	5. Position Title:	
6. Pay Perio	THIS FORM IS TO BE SUBMITTED BY SUPERVISOR EVERY PAY PERIOD WHILE EMPLOYEE IS ON COP (CONTINUATION OF PAY)	istrative Leave
8. Date Retu		
CERTIFICATION This is to certify that the above named individual has suffered a traumatic disabling work related injury, and is entitled to pay continuation as provided by 5 U. S. C., 8101 eq seq.		
9. Supervisor: (Signature)	10. Date:	
PART B - To Be Completed by Human Resources Office		

11. Status of Leave:	Calendar Days	
	This Period	To Date
Administrative Leave		
12. Human Resources Office (Signature)	13. Date:	

14. Instructions:
   a. Complete in original and 4 copies.
   b. Forward original and 2 copies to MS-HRO on the last workday of the pay period.
   c. Forward 1 copy with the T&A Card.
   d. Retain 1 copy for your records.

AGO Form 102
12 Jul 82 (Replaces AGO Form 102, 14 Oct 77, Which is Obsolete)