

## CHAPTER 10 – PERSONNEL

### Section 15 – COMPENSATION FOR INJURY/ILLNESS

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Section 15 – COMPENSATION FOR INJURY/ILLNESS

15 – COMPENSATION FOR INJURY/ILLNESS. This section gives specific direction for authorizing medical treatment, documenting injury/illness and forwarding claims and information to home units for processing with federal or state workers' compensation providers.

15.01 – Authorities. Federal and state laws and agreements authorize obtaining necessary medical services for individuals who are hurt or become ill while engaged in work activities. Specifically:

1. The Federal Employee's Compensation Act (FECA) authorizes medical care and compensation for periods of disability for regular federal government employees and federal casuals who sustain traumatic injuries and occupational diseases in the performance of duty. The Office of Workers' Compensation Programs (OWCP), U.S. Department of Labor, administers the FECA (20 CFR 10).
2. The Medical Attention Act of March 3, 1925, the Department of Agriculture Organic Act of September 21, 1944, and the Granger-Thye Act of April 24, 1950, authorize appropriated funds to be used to purchase necessary medical supplies, services, and other assistance for the immediate relief of individuals engaged in the suppression of forest fires or other hazardous work for the federal government.
3. State Workers' Compensation Programs authorize medical care and services and other assistance for individuals hired under state authorities.

15.04 – Responsibilities.

1. Incident agency is responsible for:
  - A. Ensuring that appropriate federal and state workers' compensation procedures outlined in this directive are implemented and followed.
  - B. Providing a local contact and local guidelines/procedures for the Compensation/Claims Unit Leader.

- C. Providing local treatment center information.
  - D. Establishing agreements with medical providers for Agency Provided Medical Care (APMC), if authorized.
2. Incident Management Team is responsible for providing medical attention to injured or ill individuals.
  3. Finance/Administration Section Chief is responsible for:
    - A. Overseeing the Compensation/Claims Unit to ensure appropriate injury/illness documentation and treatment authorizations are issued and completed.
    - B. Utilizing the APMC program, if available, and coordinating with the Medical Unit Leader, medical providers, the incident agency, and others who may be involved.
    - C. Providing a copy of the medical resource order log to the incident agency's Administrative Representative.
    - D. Obtaining and providing state workers' compensation information and forms for state employees assigned to the incident.
  4. Compensation/Claims Unit Leader or Compensation for Injury Specialist is responsible for:
    - A. Authorizing medical treatment through OWCP (CA-16), APMC (FS-6100-16), or state procedures.
    - B. Reviewing medical treatment documentation for work restrictions and informing the individual's supervisor of these restrictions.
    - C. Ensuring that necessary paperwork is completed, processed in a timely manner, and forwarded to the individual's home unit.
    - D. Advising individuals of their rights and responsibilities when injured or ill. (See #6 below)

- E. Providing information to the Time Unit Leader for accurate posting of timesheets for injured/ill individuals.
  - F. Providing information to the Procurement Unit Leader for posting deductible medical treatments to vendor invoices.
  - G. Following up on the status of hospitalized or medevaced incident personnel.
  - H. Informing FSC and Safety Officer of injury/illness and trends occurring on the incident.
5. Supervisor is responsible for:
- A. Obtaining first aid/medical treatment for the injured person.
  - B. Completing the supervisory portion of reporting forms and giving receipt copy of the form to the injured person.
  - C. Following up with the Compensation/Claims Unit for work restrictions and follow-up medical treatment.
  - D. Coordinate with section chief and Planning Section for work assignment modifications or release from incident.
  - E. Reporting time for injured/ill individual on a Crew Time Report (CTR), to document time spent obtaining medical treatment, travel time to and from a provider and any time loss due to injury/illness.
6. Employee is responsible for:
- A. Notifying the supervisor and requesting first aid or medical treatment if necessary.
  - B. Completing the employee portion of reporting forms.
  - C. Obtaining a witness statement

D. Promptly report to supervisor any time loss due to injury/illness; time spent obtaining medical treatment and travel time to and from a medical provider.

E. Notifying home unit supervisor when a time loss injury occurs, per agency requirements.

7. Home Unit is responsible for:

A. Initiating follow-up medical treatment under OWCP, APMC or state procedures.

B. Following standard workers' compensation procedures in cases where follow-up medical care is required and/or when the injury or illness results in lost time beyond the date of injury.

C. Submitting reportable claims and medical documentation to the appropriate workers' compensation office in a timely manner.

15.05 – Definitions. Definitions used throughout this handbook are located in the Zero Code.

1. Agency Provided Medical Care (APMC). Reasonable and initial medical care, services, and supplies provided by the incident agency for minor injuries or illnesses.

2. APMC Cases. Injury/illness cases involving only one APMC visit with no lost time charged to sick or annual leave, or Continuation of Pay (COP); and similar cases, which require only one follow-up APMC visit during non-duty hours.

3. Compensation. Compensation includes payments for medical, diagnostic and treatment services; loss of wages and/or ability to earn wages; a schedule award; participation in approved vocational rehabilitation programs; and benefits to dependents if the job related injury or illness causes the individual's death.

4. Continuation of Pay (COP). A benefit which entitles an injured regular federal government employee and federal casual, under certain circumstances, to have regular pay continued by the

home unit for a period not to exceed a total of 45 calendar days (20 CFR 10.200).

5. Controvert. To dispute the validity of an individual's claim.

6. Coverage and Eligibility. Any individual who is injured or becomes ill while engaged in an emergency incident may be provided initial emergency medical services through first aid, APMC, OWCP, or state workers' compensation programs.

7. First Aid Cases. Injuries/illnesses involving treatment by paramedics, EMTs, the Medical Unit, or a military facility where no billing for services or supplies are required and no lost time beyond the date of injury is expected.

8. Medical Care. Medical care includes first aid; physician services; surgery; hospitalization; drugs and medicines; orthopedic, prosthetic, and other appliances and supplies; and transportation expenses incurred when seeking medical treatment for job-related injury or illness.

9. Medical Resource Request Number. A medical resource request number (M#) is assigned for all medical treatment under APMC. Requests on a particular resource order are numbered sequentially, prefixed by the resource category alpha code (e.g., M-1, M-2, M-3).

Each incident is assigned a unique Incident/Project Order Number. For example, MT-LNF-076 stands for: Montana, Lolo National Forest. The medical resource request number consists of the incident order number, followed by the request number (e.g., MT-LNF-076, M-1). This combination is referred to as an M#.

10. Occupational Illness/Disease. A disease that is produced by systemic infections; continued or repeated stress or strain; exposure to toxins, poisons, or fumes; or other continued and repeated exposure to conditions of work environment over a period of at least two days (20 CFR 10.5(q)).

11. Office of Workers' Compensation Programs (OWCP). The office within the Department of Labor that is responsible for

administering the provisions of the Federal Employee's Compensation Act (FECA).

12. OWCP Chargeback Code. Job related injuries/illnesses are processed by, and charged to, the employee's home or employing unit, regardless of where the injury or illness occurs. Each agency is assigned identifying OWCP chargeback codes. The Compensation for Injury Specialist must insert the primary agency identifying OWCP code on CA forms. These codes are:

DOI, Bureau of Land Management (non-fire only)	7101
DOI, Bureau of Land Management (all fire activities)	7121
DOI, Bureau of Indian Affairs (non-fire only)	7106
DOI, Bureau of Indian Affairs (all fire activities)	7156
DOI, National Park Service (non-fire only)	7107
DOI, National Park Service (all fire activities)	7157
DOI, U.S. Fish & Wildlife Service (non-fire only)	7110
DOI, U.S. Fish & Wildlife Service (all fire activities)	7150
USDA, Forest Service (all fire activities)	8641
USDA, Forest Service (non-fire only)	8625

The chargeback codes are further broken down by alpha codes identifying specific offices and locations. Home units must complete alpha codes before submitting forms to OWCP.

13. Physician. The term "physician" includes doctors of medicine (MDs), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practices as defined by state law.

14. Pre-existing Injury or Illness/Disease. Injuries or illnesses that existed prior to the incident assignment and are aggravated, accelerated, or precipitated by factors of the current work assignment.

15. Recurrence. Disability is considered to be a recurrence when, after recovering from an injury or illness and returning to work, the individual is again disabled and there has been no event, action or apparent cause or reason for the disability except for the previous injury (20 CFR 10.5(y)).

16. Reportable Cases. Injury/illness cases involving medical expense to the individual or OWCP, lost time beyond the date of injury (time charged to sick, annual leave, Leave Without Pay (LWOP), or COP), and/or anticipated disability.

17. Reporting Office. The home unit is the reporting office that submits the individual's claim to the OWCP, follows the reporting of cases per agency procedures, and is the unit charged with the injury or illness.

18. Third-Party Cases. An injury or illness/disease caused by a person or object under circumstances that indicate there may be a legal liability on a party other than the federal or state government.

19. Traumatic Injury. A wound or other condition of the body caused by external force, including stress or strain, and which occurs during one work shift or calendar day. The injury must be identifiable by time and place of occurrence and member or function of the body affected (20 CFR 10.5(ee)).

20. Type and Source Code. Codes used on federal workers' compensation forms (CA-1, CA-2) to specify type and source for the event which initiated injury or illness.

15.1 – First Aid Cases. In order to be considered a first aid case, no lost time or billable medical treatment is expected. Medical Unit personnel record first aid cases on the Incident Medical Unit Record of Issue. Do not complete federal or state workers' compensation forms unless specifically requested by the injured/ill individual.

15.2 – Agency Provided Medical Care (APMC).

15.2-1 – Coverage and Procedures. The intent of APMC is to provide reasonable and initial medical care to individuals who suffer minor injuries or illnesses while on an incident assignment, and prompt payment to the incident medical providers. Under APMC, reasonable and initial medical assistance includes treatment by a clinic, hospital and physician services and supplies, prescriptions, and one follow-up visit. This coverage is separate from, and not under, any authority or provisions of the Federal Employee's Compensation Act (FECA) or state workers' compensation programs.

APMC should not be authorized for non-occupational injuries or illnesses unless payroll or contract invoice deduction will be made.

The incident agency is responsible for paying the medical provider and for resolving any disputed matters with the individual treated for all APMC services authorized. If the injury or illness does not meet criteria in Section 15.2-2, the individual may be responsible for reimbursing the incident agency.

State authorities vary and may not allow medical treatment for state employees under APMC. The sending unit geographic area state or federal incident business management coordinator should be contacted for the state's policy in this matter if the injured individual does not have the information. (State and National Guard employee's coverage is dependent on the contract and/or agreement under which they are dispatched.) Also refer to state information in the geographic area supplements to Chapter 50.

Military medical units will provide treatment for military personnel when available. APMC will be provided, when available, beyond what the military medical unit can provide or when a unit is not available. Military personnel will comply with incident agency reporting requirements for APMC. (Reference Military Use Handbook, Chapter 100.)

Contractors and contractor employees may utilize APMC services, if authorized by the contractor. All costs for services are deducted from the Emergency Equipment Use Invoice, OF-286, or other invoice, (Chapter 20, Section 25.3). The Compensation/Claims Unit provides the Procurement Unit with deduction documentation.

15.2-2 – Authorizing Medical Treatment. The FSC coordinates the establishment of APMC through the incident agency. APMC may be used to provide initial medical treatment for any traumatic injury, occupational illness, pre-existing condition, or non-occupational injury or illness that meets APMC criteria.

Generally, APMC may be used to authorize treatment for non-occupational injury or illness, medical conditions such as respiratory illness, colds, sore throats and similar conditions associated with exposure to smoke, dust, and weather conditions, etc.

Treatment for non-occupational injury or illness should be provided to relieve suffering. For non-occupational injuries and illness, the intent of APMC is to provide only that treatment which allows completion of the workday and provides interim care until arrangement for private medical attention, at individual's expense, is made. If an individual is treated for a non-covered injury or illness (i.e., toothache due to cavity), charges will be paid directly by the individual or processed as a deduction on the appropriate pay document. Do not complete workers' compensation forms for non-occupational injury or illness unless requested by the injured/ill individual.

The medical resource request number (M#) is issued by the Finance/Administration Section to the medical facility. One M# is issued to cover all treatment associated with a specific injury or illness. The APMC Authorization and Medical Report, Form FS-6100-16, is used to authorize treatment and for the medical provider to document patient evaluation and diagnosis each time the employee is treated (See Section 15.5, Exhibit 05). These reports are returned to the Compensation for Injury Specialist so duty status and disability determinations can be made.

Do not confuse APMC procedures with other workers' compensation programs. Do not issue a Request for Examination and Treatment, CA-16, for APMC. All APMC cases must have the M# entered on the top of all reporting forms with a notation "Paid by APMC".

If an individual or crew is on an assignment outside the United States and medical treatment is needed, a government charge card, convenience check, or other authorized and acceptable purchase method may be used to pay medical providers. APMC reporting and treatment forms must still be completed as directed, and documentation of the payment method attached.

All authorized medical services must be summarized on the APMC treatment log. The FSC provides a copy of the log to the incident agency to support payment for APMC and to facilitate follow-up. (See Section 15.5, Exhibit 06.)

15.3 – Standard Workers' Compensation Coverage and Procedures.  
Section 15 primarily addresses federal workers' compensation. State compensation coverage varies from state to state.

15.3-1 – Federal Employee’s Compensation Act (FECA). All federal employees, casuals, and personnel covered by a written agreement that contains FECA authorities, who sustain job-related injuries and illnesses in the performance of duty, are covered by FECA (20 CFR 10).

Contractors and employees of contractors, inmate crews and their custodians, National Guard mobilized by a Governor's order, and active duty military personnel are not covered by FECA.

Generally, federal employees are covered under FECA while in travel status away from their home unit. This normally applies whether they are in duty status or nonduty status (7 days a week, 24 hours a day). Individuals who remove themselves from official travel status, e.g., engaging in non-work related activities or who deviate from the authorized course of travel for personal reasons may not be covered by FECA if injury or illness results. Other non-covered situations include when the injury is caused by (a) the employee's willful misconduct, (b) intention to bring about injury or death of self or of another person, or (c) intoxication of the injured employee. In such cases, the individual may file a claim to obtain a determination from OWCP. Do not authorize medical treatment in these circumstances.

15.3-2 – Medical Care. FECA provides for medical care for the treatment of an accepted job-related injury or illness.

In serious and immediate medical care situations that may not be work related, such as apparent heart attacks, convulsions, epileptic seizures, fainting spells, and emotional disturbances, OWCP will normally pay all reasonable services and supplies required for emergency treatment, if a CA-16 is authorized and issued to the medical facility. Block 6.B.2 of the CA-16 must be checked when there is doubt that the medical condition is job-related. These situations are not normally covered under FECA and a determination by OWCP will have to be made.

15.3-3 – Authorizing Medical Care. Medical care can only be authorized for traumatic injuries. The supervisor or the Compensation for Injury Specialist authorizes initial medical treatment on a Request for Examination and/or Treatment, CA-16. (Section 15.5, Exhibit 09)

If verbal authorization is given in an emergency situation, the CA-16 must be issued within 48 hours after the medical treatment is obtained.

If the supervisor or the Compensation for Injury Specialist finds cause to refuse a request for a CA-16, the individual must be advised in writing of the reason for refusal.

Under FECA, employees may elect a physician of their choice. Emergency situations that dictate securing medical services from the nearest available facility, or physician through APMC, does not constitute selection or choice of physician. The election is still available should further treatment be necessary.

Do not issue form CA-16 for occupational illness/disease or recurrence of an injury without prior approval from OWCP. Medical conditions associated with smoke, dust, weather conditions, etc., resulting in respiratory illness, colds, sore throats, and similar illnesses are not covered under the FECA, unless medical reports establish, beyond doubt, the illness/disease is job related. Use APMC procedures covered in Section 15.2.

#### 15.3-4 – Continuation of Pay (COP).

1. Definition and Entitlement. When a regular federal government employee or federal casual sustains a traumatic injury and seeks medical treatment from a physician, the individual may claim continuation of regular pay (COP) for any wage loss due to the injury. Time loss must be documented by medical records for an individual to be eligible to receive this benefit. A disability exists only when determined by the physician per medical records. COP is available for a maximum of 45 calendar days and begins with the first day or shift of disability or medical treatment after the date of injury, provided the absence starts within 45 days after the injury. Individual should coordinate with their home unit for specific direction (20 CFR 10.200 – 10.224).

COP may not be paid after a termination date that was established prior to the injury. For casuals, COP ends when the incident to which assigned has ended or when the crew has been released from the incident to the home unit, whichever occurs first. The home unit is responsible to process pay compensation per OWCP regulations if the casual's COP ends before the disability is resolved.

2. Controversion. In questionable situations, controvert the claim on the CA-1. Under the FECA, COP does not apply in the following situations. If the case is controverted, the individual's home unit may retroactively authorize COP pending a decision by OWCP (20 CFR 10.220).

- A. The disability was not caused by a traumatic injury;
- B. The employee is not a citizen of the United States or Canada;
- C. No written claim was filed within 30 days from the date of the injury;
- D. The injury was not reported until after employment has been terminated;
- E. The injury occurred off the employing agency's premises and was otherwise not within the performance of official duties;
- F. The injury was caused by the employee's willful misconduct, intent to injure or kill himself or herself or another person, or was proximately caused by intoxication by alcohol or illegal drugs; or
- G. Work did not stop until more than 45 days following the injury.

3. COP Recording Procedures for Regular Federal Government Employees. The COP rate for a regular federal government employee is determined by the individuals home unit.

Time loss due to disability and medical treatment on the day of injury is not charged to COP. The individual is kept in regular pay status to meet base hour requirements or paid the guarantee hours (8, 9, or 10) for that calendar day (See Section 12.8). COP begins with the first day of absence for disability or medical treatment following the date of injury.

The only exception is when the injury occurs before the beginning of the workday or shift. For example, while on incident

assignment an individual is scheduled to work 0700-1900 and incurs a traumatic injury at 0630. Medical treatment is provided and the physician notes disability for that day. Charge COP for base hour requirements on the date of injury.

COP is charged for each day the individual is absent from work due to disability including intermittent periods or partial days. For example, an individual is treated and released by the doctor to return to work on the date of the injury, but is required to return for follow-up treatment during regular work hours on a subsequent day. Use COP to pay time for this follow-up treatment.

Work performed during a period of COP is recorded as regular hours of work. Return travel time from an incident assignment is considered work time for both regular government employees and casuals and is not charged to COP. Travel to and from a medical provider is compensable time (See Chapter 10, Section 12.8-6). Time spent receiving medical treatment is not compensable.

Initiate a separate column on the Emergency Firefighter Time Report (OF-288), to record COP. Note "COP" in the Rate Block. For regular government employees, indicate "COP" without clock hours for each full day of disability by indicating "COP" in the start/stop columns, and recording the total time needed to complete the guarantee hours (8, 9, or 10) for that day. Indicate partial days of disability with clock hours and total COP hours in the COP column. (See Section 15.6, Exhibit 07 for examples of recording COP.)

4. COP Recording Procedures for Casuals. Casuals are entitled to payment of COP for 8 hours per day, 7 days per week, for periods of disability until one of the following is met:

- A. Complete recovery is realized.
- B. The 45 calendar days are complete.
- C. They are released from the incident assignment because the incident is over and/or their crew is demobilized to the home unit.

Initiate a separate column on the OF-288 to record COP. Note: "COP" in the AD classification block. The COP rate for a casual is the AD hourly rate under which the casual was working at the time of injury.

Indicate "COP" in the Start/Stop columns, and record "8" in the hours column, for each full day of disability. Enter the number of hours needed to total 8 hours guarantee for each partial day of disability.

For example, if on a day subsequent to the date of injury and initial treatment, a casual worked 4 hours and was then transported to a doctor for follow-up treatment (2 hours round trip) COP entitlement would be 2 hours. Record "COP" in the Start/Stop columns and "2" in the hours column. Record 4 hours of work time and two hours of travel time in a separate column. (See Section 15.6, Exhibit 08.)

If a casual works 8 or more hours prior to seeking medical treatment, there is no charge to COP for the day. If the casual is assigned work during the time under medical restrictions, this time is not COP and must be recorded as regular work time, whether within or exceeding 8 hours of compensation for the day.

15.4 – Procedures, Documentation Requirements, and Forms  
Distribution for Federal Workers' Compensation.

1. Traumatic Injury.

<b><u>FORMS REQUIRED</u></b>	<b><u>ACTION TAKEN</u></b>
CA-1, Report of Traumatic Injury and Claim for Continuation of Pay/Compensation	Individual completes the front of form as soon as possible and preferably within 48 hours of the injury. Supervisor completes reverse side, signs, and gives receipt to individual. Individual/supervisor should obtain witness statement(s). Supervisor is responsible for completion if employee is incapacitated.

**FORMS REQUIRED**

**ACTION TAKEN**

	<p>Compensation for Injury Specialist (INJR) advises individual of rights, benefits, and responsibilities.</p> <p>INJR inserts Type and Source Code (see Section 15.5, Exhibit 01) and OWCP Chargeback Code (see Section 15.05-12).</p> <p>Compensation/Claims Unit Leader (COMP) submits completed form to the individual's home unit compensation specialist within three days of receipt.</p>
<p>CA-16, Request for Examination and Treatment</p>	<p>INJR prepares and issues one form per injury. If verbal authorization is given, forward to medical provider within 48 hours. (See Section 15.5, Exhibit 09.) Injured individual returns completed form to the INJR.</p> <p>COMP submits completed form to the individual's home unit compensation specialist within three days of receipt.</p>
<p>FS-6100-16, APMC Authorization and Medical Report</p>	<p>INJR issues one form for each visit to a medical provider. If verbal authorization is given, issue within 24 hours of treatment. Injured individual or individual acting on their behalf returns completed form to the INJR.</p> <p>COMP submits completed form to the individual's home unit compensation specialist within three days of receipt.</p>

2. Occupational Illness/Disease Covered by FECA Requiring Medical Treatment or Resulting in Lost Time.

**FORMS REQUIRED**

**ACTION TAKEN**

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

Individual completes the front of form as soon as possible and preferably within 48 hours. Supervisor completes and signs reverse side.

INJR advises individual of rights, benefits, and responsibilities.

INJR inserts Type and Source Code (see Section 15.5, Exhibit 01) and OWCP Chargeback Code (see Section 15.05-12).

COMP submits completed form to the individual's home unit compensation specialist within three days of receipt.

CA-16, Request for Examination and Treatment

Do not issue without OWCP authorization. COMP or incident agency may contact OWCP by telephone to explain the situation and request verbal authorization and instructions.

If authorized and issued, COMP submits completed form to the individual's home unit compensation specialist within three days of receipt.

FS-6100-16, APMC Authorization and Medical Report

INJR issues one form for each visit to a medical provider. If verbal authorization is given, issue within 24 hours of treatment. Injured individual returns completed form to the INJR.

COMP submits completed form to the individual's home unit compensation specialist within three days of receipt.

3. Fatality

**FORMS REQUIRED**

**ACTION TAKEN**

Follow Incident Agency Protocol

Incident Commander contacts incident agency. Prescribed agency procedures are followed.

See Section 15.5, Exhibits 02 and 03 for examples of completed CA-1 and CA-2 forms.

15.4-1 – Forms Distribution. Workers' compensation programs require submission of documents within specified time frames. In order for home units to comply, the Compensation/Claims Unit Leader sends all original workers' compensation and supporting documentation, including APMC treatment forms, to the individuals' home unit compensation specialist.

The Compensation/Claims Unit Leader:

1. Uses the Incident Injury Case File Envelope to file injury forms and documentation by individual. (See Section 15.5, Exhibit 04). Do not file Patient Evaluation forms completed by incident or contract medical personnel in the Injury Case File Envelope. These are confidential documents retained by medical personnel.
2. Completes an Injury/Illness Log to document injuries/illnesses. (See Section 15.5, Exhibit 14)
3. Provides copies of all forms and documentation to the incident agency (Chapter 40, Section 45, Exhibit 03).

15.5 – State and Cooperators Workers' Compensation. State employees and cooperators experiencing injury or illness on the incident should complete agency specific forms and notify home agency of potential workers' compensation claims per agency requirements. If state and cooperator forms are not available, appropriate federal forms may be used for initial reporting purposes. Compensation/Claims Unit Leader submits completed forms to the individual's home unit compensation specialist according to respective hiring agency policy.

15.6 – Exhibits.

15.6 – Exhibit 01

INJURY/ILLNESS TYPE AND SOURCE CODES

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**INJURY/ILLNESS TYPE CODES**

<b>100 STRUCK</b>	<b>500 CONTACT</b>
110 Struck by	510 Contact with (motion of person)
111 Struck by falling object	511 Rubbed, abraded
120 Struck against	520 Contact by (motion of object)
<b>200 FELL, SLIPPED, TRIPPED</b>	<b>600 EXERTION</b>
210 Fell on same level	610 Lifted, strained by (single action)
220 Fell on different level	620 Stressed by (repeated action)
230 Slipped, tripped (no fall)	
<b>300 CAUGHT</b>	<b>700 EXPOSURE</b>
310 Caught on	710 Inhalation
320 Caught in	720 Ingestion
330 Caught between	730 Absorption
<b>400 PUNCTURED, LACERATED</b>	<b>800 TRAVELING IN</b>
410 Punctured by	
420 Cut by	<b>999 UNCLASSIFIED</b>
430 Stung by	<b>OR</b>
430 Stung by	<b>INSUFFICIENT</b>
440 Bitten by	<b>DATA</b>

15.6 – Exhibit 01 – Continued

**INJURY/ILLNESS SOURCE CODES**

<b>0100 BUILDING OR WORKING AREA</b>	<b>0300 MACHINE OR TOOL</b>
0110 Walking/working surface (floor, street, curbs, porches)	0310 Hand tool (powered: saw, grinder, etc.)
0120 Stairs, steps	0320 Hand tool (non-powered)
0130 Ladder	0330 Mechanical power transmission apparatus
0140 Furniture, furnishing, office equipment	0340 Guard, shield (fixed, moveable deadman)
0150 Boiler pressure vessel	0350 Video Display Terminal
0160 Equipment layout (ergonomic)	0360 Pump, compressor, air pressure tool
0170 Windows, doors	0370 Heating equipment
0180 Electric, electricity	0380 Welding equipment
<b>0200 ENVIRONMENTAL CONDITION</b>	<b>0400 VEHICLE</b>
0210 Temperature extreme (indoor)	0410 Privately-owned vehicle (Includes rental)
0220 Weather (ice, rain, heat, etc.)	0411 As driver
0230 Fire, flame, smoke (not tobacco)	0412 As passenger
0240 Noise	0420 Government-owned vehicle
0250 Radiation	0421 As driver
0260 Light	0422 As passenger
0270 Ventilation	0430 Common carrier (airline, bus)
0271 Tobacco smoke	0440 Aircraft (not commercially scheduled)
0280 Stress (emotional)	0450 Boat, ship, barge
0290 Confined space	

15.6 – Exhibit 01 – Continued

**INJURY/ILLNESS SOURCE CODES – Continued**

**0500 MATERIAL HANDLING  
EQUIPMENT**

- 0510 Earthmover  
(tractor, backhoe, etc.)
- 0520 Conveyor (for material & equipment)
- 0530 Elevator, escalator, personnel hoist
- 0540 Hoist, sling chain, jack  
(for material & equipment)
- 0550 Forklift, crane
- 0560 Handtruck

**0600 DUST, MIST, VAPOR, ETC.**

- 0610 Dust (silica, coal, grain, cotton)
- 0620 Fibers
- 0621 Asbestos
- 0630 Gases
- 0631 Carbon monoxide
- 0640 Mist, steam, vapor, fume
- 0650 Particles (unidentified)

**0700 CHEMICAL, PLASTIC, ETC.**

- 0710 Chemical dry
- 0711 Corrosive
- 0712 Toxic
- 0713 Explosive
- 0714 Flammable

**0800 INANIMATE  
OBJECT**

- 0810 Box, barrel,  
container, etc.
- 0820 Paper
- 0830 Metal item,  
mineral
- 0831 Needle
- 0840 Glass
- 0850 Scrap, trash
- 0860 Wood
- 0870 Food
- 0880 Personal clothing  
apparel, shoes

**0890 Firearm**

**0900 ANIMATE  
OBJECT**

- 0910 Animal
- 0911 Bite (dog)
- 0912 Bite (other)
- 0913 Disease
- 0920 Plant
- 0930 Insect
- 0940 Human (violence)
- 0950 Human  
(communicable  
disease)
- 0960 Bacteria, virus  
(not human  
contact)

**1000 PERSONAL  
PROTECTIVE  
EQUIPMENT**

- 1010 Protective clothing  
shoes, glass/  
goggles

15.6 – Exhibit 01 – Continued

**INJURY/ILLNESS SOURCE CODES – Continued**

0720	Chemical liquid	1020	Respirator, mask
0721	Corrosive	1021	Diving equipment
0722	Toxic	1030	Safety belt, harness
0723	Explosive	1040	Parachute
0724	Flammable	<b>9999 UNCLASSIFIED</b>	
0730	Plastic	<b>OR</b>	
0740	Water	<b>INSUFFICIENT</b>	
0750	Medicine	<b>DATA</b>	

Note: Select most specific type and source for event, which initiated injury or illness. Use heading as "other" for that category. Use TYPE as "verb" and SOURCE as "noun" to describe incident. Example: Employee slipped on ice, cut hand on rock. TYPE: 210 fell on same level, SOURCE: 0220 weather.

15.6 - Exhibit 02

REPORT OF TRAUMATIC INJURY AND  
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

Reportable Injury

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.

1. Name of employee (Last, First, Middle) Miller, Amy K.		2. Social Security Number 123-45-6789	
3. Date of birth Mo. Day Yr. 04 25 66	4. Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	5. Home telephone (208) 555-1234	6. Grade as of date of injury Level 7 Step 2
7. Employee's home mailing address (include city, state, and ZIP code) 123 Alpine Road Burley, ID 88347		8. Dependents <input checked="" type="checkbox"/> Wife/Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	
9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine) Warm Lake Incident Base - Tool Sharpening Area			
10. Date injury occurred Mo. Day Yr. 07 12 11	Time 10:15 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr. 07 12 11	12. Employee's job title Forestry Technician
13. Cause of injury (Describe what happened and why) While sharpening a shovel, my hand slipped and my right thumb ran across the shovel's edge.			
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg) Right thumb laceration.		a. Occupation code E5-0462	b. Type code 420
		c. Source code 0320	OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to 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 5594.

b. Sick and/or Annual Leave

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

Signature of employee or person acting on his/her behalf: Amy K. Miller Date: 7/12/11

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

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

I was working beside Amy Miller and I saw her cut her right thumb on a shovel edge.

Name of witness Vinnie Mazzier	Signature of witness Vince Mazzier	Date signed 7/12/11
Address P.O. Box 35005	City Boise	State ID
		ZIP Code 83704

Form CA-1  
Rev. Apr. 1999

15.6 – Exhibit 02 - Continued

REPORT OF TRAUMATIC INJURY AND  
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

**Official Supervisor's Report: Please complete information requested below:**

**Supervisor's Report**

17. Agency name and address of reporting office (include city, state, and ZIP code) OWCP Agency Code  
BLM - Boise District Office 7101

3924 Development Avenue Boise, ID 83705 OSHA Site Code

18. Employee's duty station (Street address and ZIP code) ZIP Code  
BLM - Boise District Office, 3924 Development Avenue Boise, ID 83705

19. Employee's retirement coverage  CSRS  FERS  Other, (Identify)

20. Regular work hours From: 9:00  a.m.  p.m. To: 6:00  a.m.  p.m.

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

22. Date of injury 07/12/XX 23. Date notice received 07/12/XX 24. Date stopped work 07/12/XX Time: 0:15  a.m.  p.m.

25. Date pay stopped N/A 26. Date 45 day period began 07/13/XX 27. Date returned to work 07/14/XX Time: 4:00  a.m.  p.m.

28. Was employee injured in performance of duty?  Yes  No (if "No," explain)

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

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

31. Name and address of third party (include city, state, and ZIP code)  
N/A

32. Name and address of physician first providing medical care (include city, state, ZIP code)  
Dr. Converse  
1313 Water Street  
Boise, ID 83705

33. First date medical care received 07/12/XX

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

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

36. If the employing agency controverts continuation of pay, state the reason in detail.  
N/A

37. Pay rate when employee stopped work  
\$ 16.37 Per hour

**Signature of Supervisor and Filing Instructions**

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

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

Terry Gill  
Name of supervisor (Type or print)  
Terry Gill  
Signature of supervisor  
Supervisor Unit Leader  
Supervisor's Title

Date 7/12/XX  
Office phone (208) 555

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

15.6 – Exhibit 02 – Continued

REPORT OF TRAUMATIC INJURY AND  
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

**Instructions for Completing Form CA-1**

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 employees' behalf)**

**13) Cause of Injury**

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

**14) 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 filed CA-1 within thirty days of the injury, you may be 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. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

**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 39, 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 10 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.

**19) Employers Retirement Coverage**

Indicate which retirement system the employee is covered under.

**30) Was injury caused by third party?**

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

**32) Name and address of physician first providing medical care**

The name and address of the physician who first provided medical care for 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.

**33) First date medical care received**

The date of the first visit to the physician listed in item 31.

**36) If the employing agency controverts continuation of pay, state the reason in detail.**

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 was not caused by a traumatic injury.
- 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 not a citizen or a resident of the United States or Canada.
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premises" 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 45 days or more following the injury.
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

**Employing Agency - Required Codes**

**Box a (Occupation Code), Box b (Type Code),  
Box c (Source Code), OSHA Site Code**

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

**OWCP Agency Code**

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

15.6 – Exhibit 02 – Continued

REPORT OF TRAUMATIC INJURY AND  
CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

**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:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continues the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.
  - (2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.
  - (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious infringement of the head, face, or neck.
  - (4) Vocational rehabilitation and related services where directed by OWCP.
  - (5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.
- An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.
- For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

**Privacy Act**

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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

**Receipt of Notice of Injury**

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

*Amy K. Miller*

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

*7-12-XX*

At (Location)

*Warm Lake Incident Base*

Signature of Official Superior

*Jerry Gill*

Title

*Supply Unit Leader*

Date (Mo., Day, Yr.)

*7-12-XX*

15.6 - Exhibit 03

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR  
COMPENSATION, CA-2

Notice of Occupational Disease  
and Claim for Compensation

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

M-2



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. Paid by APMC

Employee Data					
1. Name of employee (Last, First, Middle) <u>Buby, Jim S.</u>			2. Social Security Number <u>234-56-789</u>		
3. Date of birth Mo. Day Yr. <u>07-12-59</u>	4. Sex <u>M</u>	5. Home telephone <u>(208) 555-8181</u>	6. Grade as of date of last exposure Level <u>6</u> Step <u>5</u>		
7. Employee's home mailing address (include city, state, and ZIP code) <u>285 Smoke Street Boise, ID 87045</u>			8. Dependents <input checked="" type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other		

Claim Information	
9. Employee's occupation <u>Forestry Technician</u>	a. Occupation code <u>95-0462</u>
10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP code) <u>Boise National Forest - Paper Fire</u>	11. Date you first became aware of disease or illness Mo. Day Yr. <u>08-22-XX</u>

12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr. <u>08-22-XX</u>	13. Explain the relationship to your employment, and why you came to this realization <u>While working as a firefighter on the Paper Fire, I was subjected to a great amount of smoke inhalation. The smoke was caused by a stop-over in the area where I was working.</u>
--	---

14. Nature of disease or illness <u>Smoke Inhalation -</u>	OWCP Use - NCI Code b. Type code <u>710</u> c. Source code <u>0230</u>
---	---

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.  
N/A

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

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

**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.

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

Signature of employee or person acting on his/her behalf Jim Buby Date 8/22/XX

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 civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

15.6 – Exhibit 03 – Continued

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR  
COMPENSATION, CA-2

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

<b>Supervisor's Report</b>	
19. Agency name and address of reporting office (include city, state, and ZIP Code)	
USDA Forest Service, Boise National Forest 1275 Oakwood Road Boise, ID ZIP Code 87045	
OWCP Agency Code B1041 OSHA Site Code	
20. Employee's duty station (Street address and ZIP Code)	
National Interagency Fire Center 3833 Development Ave. Boise ID 83705	
21. Regular work hours	22. Regular work schedule
From: 9:00 a.m. To: 6:00 p.m.	<input type="checkbox"/> Sun. <input checked="" type="checkbox"/> Mon. <input checked="" type="checkbox"/> Tues. <input checked="" type="checkbox"/> Wed. <input checked="" type="checkbox"/> Thurs. <input checked="" type="checkbox"/> Fri. <input type="checkbox"/> Sat.
23. Name and address of physician first providing medical care (include city, state, ZIP code)	
Cascade Medical Center 4720 Dear Lane Cascade, ID 83603	
24. First date medical care received	Mo. Day Yr. 08/22/XX
25. Do medical reports show employee is disabled for work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Date employee first reported condition to supervisor	Mo. Day Yr. 08/22/XX
27. Date and hour employee stopped work	Mo. Day Yr. 08/22/XX Time 2:00 p.m.
28. Date and hour employee's pay stopped	Mo. Day Yr. N/A Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
29. Date employee was last exposed to conditions alleged to have caused disease or illness	Mo. Day Yr. 08/22/XX
30. Date returned to work	Mo. Day Yr. 08/23/XX Time 8:00 a.m. Light Duty
31. If employee has returned to work and work assignment has changed, describe new duties	
Employee assigned light duty at the incident base and is not to be exposed to smoke for two days. Employee can return to fireline after two days.	
32. Employee's Retirement Coverage <input type="checkbox"/> CSRS <input checked="" type="checkbox"/> FERS <input type="checkbox"/> Other, (Specify)	
33. Was injury caused by third party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	34. Name and address of third party (include city, state, and ZIP code)
If "No," go to item 34.	N/A
<b>Signature of Supervisor</b>	
35. 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)	Date
Tammy Bull	08/22/XX
Signature of Supervisor	Office phone
Tammy Bull	(208) 555-1234
Strike Team Leader	

15.6 – Exhibit 03 – Continued

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR  
COMPENSATION, CA-2

Disability Benefits for Employees under the Federal Employees Compensation Act (FECA)	Compensation Act (FECA)
<p>The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:</p> <ol style="list-style-type: none"> <li>(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.</li> <li>(2) Payment of compensation for total or partial wage loss.</li> <li>(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.</li> <li>(4) Vocational rehabilitation and related services where necessary.</li> </ol>	<p>The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.</p> <p>An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.</p> <p>If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)</p> <p>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.</p>
<p><b>Privacy Act</b></p>	

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

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

Receipt of Notice of Occupational Disease or Illness		
<p>This acknowledges receipt of notice of disease or illness sustained by: (Name of injured employee)</p>		
<p><u>Tim Ruby</u></p>		
<p>I was first notified about this condition on (Mo., Day, Yr.) <u>08/22/xx</u></p>		
<p>At (Location)</p>		
<p><u>Paper Fire - Boise National Forest</u></p>		
<p>Signature of Official Superior <u>Sammy Bull</u></p>	<p>Title <u>Strike Team Leader</u></p>	<p>Date (Mo., Day, Yr.) <u>08/22/xx</u></p>
<p>This receipt should be retained by the employee as a record that notice was filed.</p>		
<p style="text-align: right;">Form CA-2 Rev. Jan. 1997</p>		

15.6 – Exhibit 03 – Continued

NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR  
COMPENSATION, CA-2

**INSTRUCTIONS FOR COMPLETING FORM CA-2**

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

**Employee (or person acting on the employee's behalf)**

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

**1) Employee's statement**

In a separate narrative statement attached to the form, the employee must submit the following information:

- a) A detailed history of the disease or illness from the date it started.
- b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.
- c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.
- d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)
- e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

**2) Medical report**

- a) Dates of examination or treatment.
- b) History given to the physician by the employee.
- c) Detailed description of the physician's findings.
- d) Results of x-rays, laboratory tests, etc.
- e) Diagnosis.
- f) Clinical course of treatment.
- g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

**3) Wage loss**

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

**Supervisor (Or appropriate official in the employing agency)**

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible 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 must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

- a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per day and days per week, requested above.
- b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.
- c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.
- d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)
- e) Review and comment on the accuracy of the employee's statement requested above.

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

**Item Explanations: Some of the items on the form which may require further clarification are explained below.**

**14. Nature of the disease or illness**

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

**19. Agency name and address of reporting office**

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

**23. 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.

**24. First date medical care received**

The date of the first visit to the physician listed in item 23.

**32. Employee's Retirement Coverage.**

Indicate which retirement system the employee is covered under.

**33. Was the injury caused by third party?**

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

**Employing Agency - Required Codes**

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

**OWCP Agency Code**

This is a four digit (or four digit 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.

15.6 – Exhibit 04

SAMPLE INCIDENT INJURY CASE FILE ENVELOPE, OF-313

NAME OF CLAIMANT <i>Millev Anna</i>	DATE OF INJURY OR ILLNESS <i>07-12-XX</i>	APMC <input type="checkbox"/> OWCP <input checked="" type="checkbox"/>	FIRST AID ONLY <input type="checkbox"/>
INCIDENT/COMPLEX NAME <i>Warm Lake</i>	INCIDENT NUMBER <i>ID-1800-077</i>	UNIT LOG NUMBER <i>M-None</i>	

  

CLAIMANT ASSIGNED TO: \_\_\_\_\_  
(Crew Name or OH Section)

CLAIMANT'S HOME UNIT: *BLM - Boise D.O.*  
(Agency)

*3124 Development Ave.*  
(Address)

*Boise, ID 83705*  
(City, State and Zip Code)

*(208) 555-1212*  
(Telephone No. with Area Code)

SUPERVISOR ON INCIDENT: *Terry Hill*

SUPERVISOR'S HOME UNIT: *BLM - Boise D.O.*  
(Agency)

*3124 Development Ave.*  
(Address)

*Boise, ID 83705*  
(City, State and Zip Code)

*(208) 555-1212*  
(Telephone No. with Area Code)

  

**CHECK LIST FOR CASE FILES**

(Indicate Whether Completed)	YES (Date)	NO
*CA-1 - Report of Injury	<i>7-12-XX</i>	
*CA-2 - Report of Illness		
CA-16 - Request for Examination and/or Treatment	<i>7-12-XX</i>	
FS-6100-16 - Agency Provided Medical Care Authorization and Medical Report		
CA-17 - Duty Status Report	<i>7-12-XX</i>	
HCFCA-1500 - Health Insurance Claim Form		
Follow-up Action Needed		

\*NOTE: ORIGINAL form must go to employee's home (or hiring) unit. Retain COPY in the Incident Finance file.

Follow-up Needs/Comments: *Last time injury stitches need to be removed by personal physician.*

  

COMPENSATION FOR INJURY SPECIALIST/UNIT LEADER NAME <i>Terry Staccast</i>	HOME UNIT TELEPHONE NUMBER WITH AREA CODE <i>(208) 123-4567</i>	FINANCE/ADMINISTRATION SECTION CHIEF INITIALS <i>J</i>
--	--	---

**INCIDENT INJURY CASE FILE ENVELOPE**

7540-01-475-4398  
50315-01

OPTIONAL FORM 313 (Rev. 4-2000)

15.6 – Exhibit 05

APMC AUTHORIZATION AND MEDICAL REPORT, FS-6100-16

USDA-Forest Service <b>AGENCY PROVIDED MEDICAL CARE AUTHORIZATION AND MEDICAL REPORT</b> (Physician or Medical Facility Form may be used for Medical Report) (Refer to FSH 5109.12)	
<b>Part A Authorization</b>	
1. Medical Resource Request "M Number" <u>M-2</u>	
2. Procurement Identification (BPA/Field PO No., etc)	
3. Responsible Payment Unit <u>Boise National Forest</u>	
4. Employee Name <u>Lynn Standley</u>	5. Social Security No. <u>234-56-7891</u>
6. Employing Agency <u>USDA-Forest Service, Boise National Forest</u>	8. Date of Injury <u>08/22/xx</u>
7. Home Unit and Address <u>Boise National Forest 1275 Oakwood Road Boise, ID 87045</u>	
9. Physician/Medical Facility: <u>Cascade Medical Center 4720 Deer Lane Cascade, ID 88603</u>	
<small>Please provide initial diagnosis and treatment medically necessary for injury/illness. Surgery, other than emergency, and/or hospitalization requires further authorization. Please complete the following medical report at the time of treatment and give to the employee for return to our office.</small>	
10. Authorizing Signature <u>Margo Hornback Comp/Claims Unit Leader</u>	11. Date <u>08/22/xx</u>
<b>Part B Attending Physician's Report</b>	
1. Evaluation or Diagnosis: <u>Smoke inhalation resulting in a bronchial infection.</u>	
2. Description of Treatment <u>Bronchial therapy and medication</u>	
3. Medicine Prescribed and Potential Side Effects: <u>10 days antibiotics</u>	
4. Work Restrictions (if any) and length of restrictions. <u>Do not expose to smoke for 2 days - then can return to fireline duty. Can work in a non-smoky environment.</u>	
5. Physician's Signature <u>A. Worcester, M.D.</u>	6. Date <u>8/22/xx</u>

15.6 – Exhibit 05 – Continued

APMC AUTHORIZATION AND MEDICAL REPORT, FS-6100-16

**Employing Office Instructions**

Medical treatment for this injury/illness was provided by our Agency through procurement with medical providers under the *Agency Provided Medical Care (APMC)* program. These procedures are entirely apart from and not under the authority or provisions of FECA/OWCP, and do not require issuing a CA-16. However, a CA-1 or CA-2 was completed in all cases for the employee's protection.

**Do not pay invoices or statements attached to CA forms. Do not forward to OWCP for payment.**

If, (1) no further medical treatment is necessary, (2) there is no lost time due to the injury/illness, and (3) this initial treatment did not involve surgery or hospitalization, file the CA-1/CA-2 and medical documentation in the Employee's Medical Folder for record purposes.

If any one of the following conditions occurs, initiate appropriate OWCP procedures:

1. For lost time cases which occurred on the incident assignment or following the employee's return (and are supported by the attached medical documentation), but no further medical treatment is required, submit CA-1/CA-2 and the medical report from the medical provider to OWCP as part of the claim package. Provide explanation to OWCP that all medical services were paid by the Agency. Grant COP and provide form CA-3 to OWCP as appropriate in traumatic injury cases.
2. Where emergency surgery or hospitalization was provided by the medical facility in conjunction with APMC, submit CA-1/CA-2 and the medical reports to OWCP as outlined in item 1 above.
3. Where followup treatment is necessary or there is loss of wages, follow standard OWCP procedures. *This includes issuing CA-16 as appropriate to the physician of the employee's choice. File the claim with your OWCP District Office.*

Situations may arise where the physician provided by this Agency determined that the employee was fit for light or regular duty and subsequent evaluation shortly thereafter by the physician selected by the employee indicates the employee is disabled. While this requires resolution by OWCP, the employee must receive continuation of pay, if other requirements for COP are met, pending OWCP's decision.

If you have any questions or problems, please contact Incident Unit Headquarter's Compensation Specialist

Compensation Specialist Name Marg Hornback  
Agency Unit Headquarters Boise National Forest  
Phone Number 208-436-5678





15.6 – Exhibit 08

EMERGENCY FIREFIGHTER TIME REPORT, OF-288  
SHOWING COP FOR A CASUAL

EMERGENCY FIREFIGHTER TIME REPORT												1. Identification Number <b>F 7114481</b>											
2. Social Security Number <b>012-47-0001</b>			3. Initial Employment (X one) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			4. Type of Employment (X one) <input checked="" type="checkbox"/> Casual <input type="checkbox"/> Regular Gov't. Employee <input type="checkbox"/> Other			5. Transferred From <b>N/A</b>			6. Hired At <b>ID: BOD</b>			7. Employee Has (X one) <input checked="" type="checkbox"/> Been Discharged <input type="checkbox"/> Out			8. Entitled To Return (Total Time) (X one) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			9. Entitled To Return Transportation (X one) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
ZIP CODE MUST BE ENTERED BELOW												IN CASE OF ACCIDENT NOTIFY											
10. Name (First, Middle, Last) <b>Jose Valdez</b>						15. Name <b>Maria Valdez</b>																	
11. Street Address <b>842 West End</b>						16. Street Address <b>(same)</b>																	
12. City <b>Nampa</b>			13. State <b>ID</b>			14. Zip Code <b>83651</b>			17. City <b>(same)</b>			18. State <b>ID</b>			19. Telephone No. (Include Area Code) <b>208-555-3001</b>								
20. FIRE LOCATION IDENTIFICATION																							
Column A				Column B				Column C				Column D											
1. Fire Name <b>River Road</b>	2. Fire No. <b>ID-PNF-030</b>	3. Fire Location <b>PNF</b>	4. Fire Date <b>FETZ 11.68</b>	1. Fire Name <b>River Road</b>	2. Fire No. <b>ID-PNF-030</b>	3. Fire Location <b>PNF</b>	4. Fire Date <b>FETZ 11.68</b>	1. Fire Name <b>River Road</b>	2. Fire No. <b>ID-PNF-030</b>	3. Fire Location <b>PNF</b>	4. Fire Date <b>FETZ 11.68</b>	1. Fire Name <b>River Road</b>	2. Fire No. <b>ID-PNF-030</b>	3. Fire Location <b>PNF</b>	4. Fire Date <b>FETZ 11.68</b>								
5. Date and Time a. Year <b>XXXX</b>	6. Date and Time a. Year <b>XXXX</b>	7. Date and Time a. Year <b>XXXX</b>	8. Date and Time a. Year <b>XXXX</b>	5. Date and Time a. Year <b>XXXX</b>	6. Date and Time a. Year <b>XXXX</b>	7. Date and Time a. Year <b>XXXX</b>	8. Date and Time a. Year <b>XXXX</b>	5. Date and Time a. Year <b>XXXX</b>	6. Date and Time a. Year <b>XXXX</b>	7. Date and Time a. Year <b>XXXX</b>	8. Date and Time a. Year <b>XXXX</b>	5. Date and Time a. Year <b>XXXX</b>	6. Date and Time a. Year <b>XXXX</b>	7. Date and Time a. Year <b>XXXX</b>	8. Date and Time a. Year <b>XXXX</b>								
9. Total Hours <b>25.50</b>	9. Total Hours <b>16.50</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>25.50</b>	9. Total Hours <b>16.50</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>25.50</b>	9. Total Hours <b>16.50</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>25.50</b>	9. Total Hours <b>16.50</b>	9. Total Hours <b>24.00</b>	9. Total Hours <b>24.00</b>								
10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/01 - 08/10/04</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>	10. Gross Amount (Start 7 x Start 9) <b>08/105 - 08/107</b>								
11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/01 - 08/10/04</b>	11. Inclusive Dates <b>08/105 - 08/107</b>	11. Inclusive Dates <b>08/105 - 08/107</b>								
12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>	12. Time Officer's Signature <b>A. Smith</b>								
13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/04/xx</b>	13. Date Signed <b>08/07/xx</b>	13. Date Signed <b>08/07/xx</b>								
21. SHOW "H" FOR HAZARD PAY AND "E" PLUS % FOR ENVIRONMENTAL DIFFERENTIAL IN THE "HOURS" COLUMN FOR REGULAR EMPLOYEES.												22. Complementary Record											
A. Comm. NO 2802	B. Rate	C. Hours/Hours	D. Accounting Classification (M, S, ES, MS, BS, ES)	E. Object Class (M, S, ES, MS, BS, ES)	F. Amount	G. Date	H. Item	I. Amount															
23. Remarks <b>08/04 injured at 0150 08/08 released from hospital, transported home.</b>										24. ADD Check Number and Stamp													
NOTE: The above items are correct and proper for payment from available appropriations.																							
25. Employee (Signature) <b>Jose Valdez</b>						26. Time Officer (Signature) <b>Amy Smith</b>																	

15.6 – Exhibit 09

REQUEST FOR EXAMINATION AND TREATMENT, CA-16

Authorization for Examination  
And/Or Treatment

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



The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under 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-106.

OMB No.: 1215-0103  
Expires: 09-30-81

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service: <i>Dr. Converse 1313 Water Street Boise ID 83705</i>		
2. Employee's Name (last, first, middle) <i>Miller, Amy K.</i>	3. Date of injury (mo., day, yr.) <i>07-12-XX</i>	4. Occupation <i>Forestry Technician</i>
5. Description of injury or Disease: <i>Right thumb laceration</i>		
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. B. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> 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 to the injury or to the employment.		
7. If a Disease or illness is involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official: <i>Gerry Stewart</i>	
	9. Name and Title of Authorizing Official: (Type or print clearly) <i>Gerry Stewart Comp/Claims Unit Leader</i>	
10. Local Employing Agency Telephone Number: <i>209-555-0123</i>	11. Date (mo., day, year) <i>07-12-XX</i>	
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 <i>1111 Third Avenue, Suite 615 Seattle, WA 98101</i>	13. Name and Address of Employee's Place of Employment:  Department of Agency <i>USDI</i>  Bureau or Office <i>BLM</i>  Local Address (including ZIP Code) <i>3924 Development Avenue Boise, ID 83705</i>	

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

Form CA-16  
Rev. Oct. 1988

15.6 – Exhibit 09 – Continued

REQUEST FOR EXAMINATION AND TREATMENT, CA-16

PART B - ATTENDING PHYSICIAN'S REPORT			
14. Employee's Name (last, first, middle) <i>Miller, Amy K.</i>			
15. What History of Injury or Disease Did Employee Give You? <i>Lacerated right thumb while sharpening a shovel.</i>			
16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		16a. IDC-9 Code [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	
17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.) <i>laceration @ thumb</i>		18. What is Your Diagnosis? <i>laceration @ thumb</i>	
19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		18a. IDC-9 Code [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	
20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		21. Is Additional Hospitalization Required? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
22. Surgery (if any, describe type) <i>N/A</i>		23. Date Surgery Performed (mo., day, year) <i>N/A</i>	
24. What (Other) Type of Treatment Did You Provide? <i>3 stitches</i>		25. What Permanent Effects, if Any, Do You Anticipate? <i>None</i>	
26. Date of First Examination (mo., day, year) <i>07-12-XX</i>	27. Date(s) of Treatment (mo., day, year) <i>07-12-XX</i>	28. Date of Discharge from Treatment (mo., day, year) <i>07-12-XX</i>	
29. Period of Disability (mo., day, year) (if termination date unknown, so indicate) Total Disability: From <i>7-12-XX</i> To <i>7-14-XX</i> Partial Disability: From [ ] To [ ]		30. Is Employee Able to Resume <input type="checkbox"/> Light Work Date: [ ] [ ] [ ] [ ] <input checked="" type="checkbox"/> Regular Work Date: <i>07-14-XX</i> <i>After follow-up Appointment 7/14</i>	
31. If Employee is Able to Resume Work, Has He/She been Advised? <i>Must wear gloves while working.</i>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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. <i>N/A</i>			
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. <i>Follow-up appointment in two days, then, Return in 10 days to have stitches removed. May see doctor at home for this follow-up.</i>			
34. Do You Specialize? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.  <i>Louis Converse</i>		36. Address (No., Street, City, State, Zip Code) <i>1313 Water Street Boise, ID 83705</i>	
		37. Tax Identification Number: <i>92-13798</i>	38. Date of Report: <i>07-12-XX</i>

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

15.6 – Exhibit 10

ATTENDING PHYSICIAN'S REPORT, CA-20

Attending Physician's Report		U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs			
<b>Record of Examination:</b>					
1. Patient's name Last First Middle Miller Amy K		2. Date of injury mo. day yr. 07, 22, XY		3. OWCP File Number new claim	
4. What history of injury (including disease) Did patient give you? Lacerated @ thumb while sharpening a shovel.					
5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (if yes, please describe) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					ICD-9 Code
6. What are your findings? (Include results of X-Rays, laboratory reports, etc.) lacerated @ thumb					
7. What is your diagnosis? lacerated @ thumb					ICD-9 Code
8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
9. Did injury require hospitalization? If no, go to item #12 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10. Date of admission mo. day yr.		11. Date of discharge mo. day yr.	
12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
13. What treatment did you provide? Removed stitches from @ thumb					
14. Date of first examination mo. day yr. 07, 22, XY		15. Date(s) of treatment mo. day yr. 07, 22, XY		16. Date of discharge from treatment mo. day yr. 07, 22, XY	
17. Period of total disability N/A From mo. day yr. Thru mo. day yr.		18. Period of Partial Disability N/A From mo. day yr. Thru mo. day yr.		19. Date employee able to resume light work N/A mo. day yr.	
20. Date employee is able to resume regular work mo. day yr. 07, 22, XY		21. Has employee been advised that he/she can return to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		22. If yes, on what date was he/she advised? mo. day yr. 07, 22, XY	
23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #24 if necessary.) N/A					24. Are any permanent effects expected as a result of this injury? If yes, describe in item #24. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Remarks Patient complains of stiffness in thumb joint. Prescribed strengthening exercises. Advised to return as needed for follow-up.					
26. If you have referred the employee to another physician provide the following: Name Address City State Zip				Specialty 27. What was the reason for this referral? <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment	
<b>Signature</b>					
28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.					
Signature of Physician Dr. Lynn Harvey				Date 7-22-XY	
29. Name of Physician Dr. Harvey				30. Tax ID Number 92-00032	
Address Suite 100 Medical Building				31. Do you specialize? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
City Burley		State ID		Zip 88347	
32. If yes, indicate specialty					

15.6 – Exhibit 10 – Continued

ATTENDING PHYSICIAN'S REPORT, CA-20

**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  
*US Department of Labor*  
*1111 Third Avenue, Suite 615*  
*Seattle, WA 98101*

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**Public Burden Statement**

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

For Sale by the Superintendent of Documents, U.S. Government Printing Office  
Washington, DC 20402

★ U.S. GPO: 1994-573-004/81088

15.6 – Exhibit 11

DUTY STATUS REPORT, CA-17

Duty Status Report

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



This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.). Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

OMB No. 1215-0103  
Expires: 10-31-84  
OWCP File Number  
(if known)

<b>SIDE A - Supervisor: Complete this side and refer to physician</b>			<b>SIDE B - Physician: Complete this side</b>																																																																																																						
1. Employee's Name (Last, first, middle) Miller, Amy K.			8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? <input type="checkbox"/> Yes <input type="checkbox"/> No (If not, describe)																																																																																																						
2. Date of Injury (Month, day, yr.) 07-12-XX		3. Social Security No. 123-45-6789																																																																																																							
4. Occupation Forestry Technician			9. Description of Clinical Findings																																																																																																						
5. Describe How the Injury Occurred and State Parts of the Body Affected Lacerated @ thumb while sharpening tools			10. Diagnosis Due to Injury																																																																																																						
6. The Employee Works 8 Hours Per Day 5 Days Per Week			11. Other Disabling Conditions																																																																																																						
7. 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.			12. Employee Advised to Resume Work? <input type="checkbox"/> Yes, Date Advised <input type="checkbox"/> No																																																																																																						
<table border="1"> <thead> <tr> <th>Activity</th> <th>Continuous</th> <th>Intermittent</th> <th>Continuous</th> <th>Intermittent</th> </tr> </thead> <tbody> <tr> <td>a. Lifting/Carrying: State Max Wt.</td> <td>#lbs.</td> <td>#lbs.</td> <td>#lbs.</td> <td>#lbs.</td> </tr> <tr> <td>b. Sitting</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Standing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Walking</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Climbing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>f. Kneeling</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>g. Bending/Stooping</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>h. Twisting</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>i. Pulling/Pushing</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>j. Simple Grasping</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>k. Fine Manipulation (includes keyboarding)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>l. Reaching above Shoulder</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>m. Driving a Vehicle (Specify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>n. Operating Machinery (Specify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>o. Temp. Extremes</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>p. High Humidity</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>q. Chemicals, Solvents, etc. (Identify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>r. Fumes/Dust (Identify)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>s. Noise (Give dBA)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>			Activity	Continuous	Intermittent	Continuous	Intermittent	a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	#lbs.	#lbs.	b. Sitting					c. Standing					d. Walking					e. Climbing					f. Kneeling					g. Bending/Stooping					h. Twisting					i. Pulling/Pushing					j. Simple Grasping					k. Fine Manipulation (includes keyboarding)					l. Reaching above Shoulder					m. Driving a Vehicle (Specify)					n. Operating Machinery (Specify)					o. Temp. Extremes					p. High Humidity					q. Chemicals, Solvents, etc. (Identify)					r. Fumes/Dust (Identify)					s. Noise (Give dBA)					13. Employee Able to Perform Regular Work Described on Side A? <input type="checkbox"/> Yes, If so <input type="checkbox"/> Full-Time or <input type="checkbox"/> Part-Time <input type="checkbox"/> No. If not, complete below:		
Activity	Continuous	Intermittent	Continuous	Intermittent																																																																																																					
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	#lbs.	#lbs.																																																																																																					
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s. Noise (Give dBA)																																																																																																									
14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No (Describe)			15. Date of Examination																																																																																																						
16. Date of Next Appointment			17. Specialty																																																																																																						
18. Physician's Signature			19. Tax Identification Number																																																																																																						
20. Date			21. Date																																																																																																						

Doctor Completes This Side

While on incident assignment, may work extended shifts in rough terrain as a firefighter.

15.6 – Exhibit 11 – Continued

DUTY STATUS REPORT, CA-17

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT

- SUPERVISOR:** Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.
- PHYSICIAN:** Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

USDI - BLM  
3924 Development Ave  
Boise, ID 83705

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

1111 Third Avenue, Suite 615  
Seattle, WA 98101

**CERTIFICATION:** BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Form CA-17  
Rev. July 1991

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

15.6 – Exhibit 12

EVIDENCE REQUIRED IN SUPPORT OF A CLAIM FOR  
OCCUPATIONAL DISEASE, CA-35

Evidence Required in Support of a Claim  
for Occupational Disease

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



All of the following information should be submitted with Form CA-2. Please return the checklist with your statements attached. Check off each item as it is completed or let us know when we can expect the information. All material submitted should be legible and specific.

FROM EMPLOYEE		FROM EMPLOYING AGENCY	
1. Give a detailed description of factors of employment believed responsible for condition. Be specific as to the duration and nature of the factors: for instance weights carried, distances walked, chemicals used, or other relevant job factors.	✓	5. Review and comment on employee's statement provided in response to Item no. 1.	
2. Give the history of the condition from first awareness of the problem. Include description of all home treatment and professional care as well as symptoms.		6. If employee's job differs from official description, describe exactly his/her duties.	
3. Describe any prior similar problem, with dates of onset, history, medical care received, and copies of the medical records of your treatment.		7. Give a day-by-day listing of leave and leave without pay used due to this condition.	
4. Attach or forward a medical report from your physician to include the following items:  a. Dates of examination and treatment.  b. History given by you.  c. Detailed description of findings.  d. Results of all diagnostic tests.  e. Diagnosis.  f. The clinical course of treatment followed.  g. Doctor's opinion, with reasons for such opinion, as to the relationship between any condition you may now have and the factors of employment identified in item no. 1 above.		8. Attach copies of the employee's:  a. SF-171, Application for Employment.  b. Position description with physical requirements.  c. Pertinent dispensary records.  d. Most recent SF-50, Notification of Personnel Action.	

