

15.5 – Exhibit 03

AUTHORIZATION FOR EXAMINATION AND/OR 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-108.

OMB No.: 1215-0103
 Expires: 09-30-91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service: Dr. Converse 1313 Water Street Boise, ID 83705			
2. Employee's Name (last, first, middle) Miller, Amy K.	3. Date of Injury (mo., day, yr.) 7/12/08	4. Occupation Forestry Technician	
5. Description of Injury or Disease: Right Thumb Laceration			
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 the 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: 	
		9. Name and Title of Authorizing Official: (Type or print clearly) Sissel Batey Comp/Claims Unit Leader	
10. Local Employing Agency Telephone Number: (208) 555-0123		11. Date (mo., day, year) 7/12/08	
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 1111 Third Avenue, Suite 650 Seattle, WA 98101-3212 (See Exhibit 04 for OWCP District Office list)		13. Name and Address of Employee's Place of Employment: Department or Agency U. S. Department of Interior Bureau or Office Bureau of Land Management Local Address (Including Zip Code) 3924 Development Avenue Boise, ID 83705	

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 the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, 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.

15.5 – Exhibit 04

U.S. DEPARTMENT OF LABOR OWCP DISTRICT OFFICES

<p>District Office 1 - Boston</p> <p>(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) U.S. Dept. of Labor, OWCP JFK Federal Building, Room E-260 Boston, MA 02203 (617) 624-6600</p>	<p>District Office 9 - Cleveland</p> <p>(Indiana, Michigan, Ohio; All special claims and all areas outside the U.S., its possessions, territories and trust territories) U.S. Dept. of Labor, OWCP 1240 East Ninth Street, Room 851 Cleveland, OH 44199 (216) 357-5100</p>
<p>District Office 2 - New York</p> <p>(New Jersey, New York, Puerto Rico, and the Virgin Islands) U.S. Dept. of Labor, OWCP 201 Varick Street, Room 740 New York, NY 10014 (646) 264-3000</p>	<p>District Office 10 - Chicago</p> <p>(Illinois, Minnesota, Wisconsin) U.S. Dept. of Labor, OWCP 230 South Dearborn Street, Eighth Floor Chicago, IL 60604 (312) 596-7157</p>
<p>District Office 3 - Philadelphia</p> <p>(Delaware, Pennsylvania, and West Virginia; Maryland when the claimant's residence has a zip code beginning 21***) U.S. Dept. of Labor, OWCP Curtis Center, Suite 715 East 170 S. Independence Mall West Philadelphia, PA 19106-3308 (215) 861-5481 or 5482</p>	<p>District Office 11 - Kansas City</p> <p>(Arkansas, Iowa, Kansas, Missouri, and Nebraska; all employees of the Department of Labor, except Job Corps enrollees, and their relatives) U.S. Dept. of Labor, OWCP Two Pershing Square Building 2300 Main Street, Suite 1090 Kansas City, MO 64108-2416 (816) 502-0301</p>
<p>District Office 6 - Jacksonville</p> <p>(Alabama, Florida, Georgia, Kentucky, Mississippi, No. Carolina, So. Carolina, and Tennessee) U.S. Dept. of Labor, OWCP 400 West Bay Street, Room 826 Jacksonville, FL 32202 (904) 357-4777 or 4778</p>	<p>District Office 12 - Denver</p> <p>(Colorado, Montana, No. Dakota, So. Dakota, Utah, and Wyoming) U.S. Dept. of Labor, OWCP 1999 Broadway, Suite 600 Denver, CO 80202 (720) 264-3000</p>
<p>District Office 13 - San Francisco</p> <p>(Arizona, California, Hawaii, and Nevada) U.S. Dept. of Labor, OWCP 90 Seventh St., Suite 15300 San Francisco, CA 94103 (415) 625-7500</p>	<p>District Office 16 - Dallas</p> <p>(Louisiana, New Mexico, Oklahoma and Texas) U.S. Dept. of Labor, OWCP 525 South Griffin Street, Room 100 Dallas, TX 75202 (972) 850-2300</p>
<p>District Office 14 - Seattle</p> <p>(Alaska, Idaho, Oregon, and Washington) U.S. Dept. of Labor, OWCP 1111 Third Avenue, Suite 650 Seattle, WA 98101-3212 (206) 398-8100</p>	<p>District Office 25 - Washington D.C.</p> <p>(District of Columbia, Virginia; Maryland when the claimant's residence has a zip code other than 21***) U.S. Dept. of Labor, OWCP 800 N. Capitol Street, N.W., Room 800 Washington, D.C. 20211 (202) 513-6800</p>

15.5 – Exhibit 04 – Continued

U.S. DEPARTMENT OF LABOR OWCP DISTRICT OFFICES

U.S. Department of Labor OWCP District Office Map



15.5 – Exhibit 05

APMC AUTHORIZATION AND MEDICAL REPORT, FS-6100-16

USDA-Forest Service		AGENCY PROVIDED MEDICAL CARE AUTHORIZATION AND MEDICAL REPORT		FS 6100-16 (01/05)
(Physician or Medical Facility Form may be used for Medical Report) (Refer to FSH 5109.34, IIBMH Chptr 10, Section 15)				
Part A Authorization				
1. Medical Resource Request "M Number" M-2				
2. Procurement Identification (BPA/Field PO No., etc)				
3. Responsible Payment Unit Boise National Forest				
4. Employee Name Tim Ruby		4a. Occupation Forestry Tech		5. Social Security No. 123-45-6789
6. Employing Agency Forest Service, Boise National Forest			8. Date of Injury 08/22/XXXX	
7. Home Unit and Address Boise National Forest 1275 Oakwood Road Boise, ID 87045			Send Bills To:	
9. Physician/Medical Facility: Cascade Medical Center 4720 Deer Lane Cascade, ID 88603				
9a Description of Injury or Disease: Smoke Inhalation 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.				
10. Authorizing Signature (Agency Admin/Line Officer, FSC, or COMP) <i>Margo Hankins COMP</i>			11. Date 08/22/XXXX	
Part B Attending Physician's Report				
1. Evaluation or Diagnosis: Smoke inhalation resulting in a bronchial infection.				
2. Description of Treatment: Broncial therapy and medication				
3. Medicine Prescribed and Potential Side Effects: 10 days antibiotics				
4. Work Restrictions (if any) and length of restrictions. Do not expose to smoke for 2 days – then can return to fireline duty. Can work in a non-smoky environment.				
5. Physician's Signature <i>J. Worcester M.D.</i>			6. Date 08/22/XXXX	

Attachment: Employee's CA-1/CA-2 (white copy)
 Medical Facility CA-1/CA-2 (pink copy)
 Incident Unit Headquarters CA-1/CA-2 (yellow copy)

OVER

15.5 – 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. Under these circumstances only, 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	Margo Hornback
Agency Unit Headquarters	Boise National Forest
Phone Number	208-555-1212

15.5 – Exhibit 08

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

EMERGENCY FIREFIGHTER TIME REPORT										1. Identification Number F 7114481	
2. Social Security Number 987- 65- 4321		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		6. Hired At ID-BOD		7. Employee Has (X One) <input type="checkbox"/> Been Discharged <input type="checkbox"/> Quit		8. Entitled To Return Travel 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 EMERGENCY NOTIFY	
10. Name (First, Middle, Last) Jose Valdez					15. Name Maria Valdez						
11. Street Address 842 West End					16. Street Address (Same)						
12. City Nampa		13. State ID		14. Zip Code 83651		17. City		18. State		19. Telephone No. (include Area Code) 208-555-4321	
20. FIRE LOCATION IDENTIFICATION											
Column A			Column B			Column C			Column D		
1. Fire Name Warm Lake			1. Fire Name Warm Lake			1. Fire Name Warm Lake			1. Fire Name Warm Lake		
2. Fire No. ID-BOD-005161			3. Unit Code			2. Fire No. ID-BOD-005161			3. Unit Code		
4. Fire Location BOD			5. State ID			4. Fire Location BOD			5. State OR		
6. Firefighter Classification FFT2 / AD-C			7. Rate 13.24			6. Firefighter Classification FFT2 / AD-C			7. Rate 13.24		
8. Date and Time a. Year XXXX			8. Date and Time a. Year XXXX			8. Date and Time a. Year XXXX			8. Date and Time a. Year XXXX		
Mo. b. Day c. Start d. Stop e. Hours f.			Mo. b. Day c. Start d. Stop e. Hours f.			Mo. b. Day c. Start d. Stop e. Hours f.			Mo. b. Day c. Start d. Stop e. Hours f.		
08 01 2000 2400 4.00T			08 04 Guarantee 6.50			08 05 COP 8.00			08 08 1000 T		
08 02 0001 0130 1.50T			/			08 06 COP 8.00			Carol Smith		
08 02 1800 2400 6.00						08 07 COP 8.00					
08 02 Guarantee 0.50											
08 03 0001 0800 8.00											
08 03 2000 2400 4.00											
08 04 0001 0130 1.50											
9. Total Hours → 25.50			9. Total Hours → 6.50			9. Total Hours → 24.00			9. Total Hours →		
10. Gross Amount (item 7 X item 9) →			10. Gross Amount (item 7 X item 9) →			10. Gross Amount (item 7 X item 9) →			10. Gross Amount (item 7 X item 9) →		
11. Inclusive Dates → 08/01 - 08/04			11. Inclusive Dates → 4-Aug			11. Inclusive Dates → 08/05 - 08/07			11. Inclusive Dates →		
12. Time Officer's Signature /s/ Carol Smith			12. Time Officer's Signature /s/ Carol Smith			12. Time Officer's Signature /s/ Carol Smith			12. Time Officer's Signature		
13. Date Signed 08/04/XX			13. Date Signed 08/04/XX			13. Date Signed 08/07/XX			13. Date Signed		
21. SHOW 'H' FOR HAZARD PAY AND 'E' PLUS % FOR ENVIRONMENTAL DIFFERENTIAL IN THE 'HOURS' COLUMN FOR REGULAR EMPLOYEES.						22. Commissary Record					
A. Comm. BO 2800		B. Rate		C. Miles * / Hours		D. Accounting Classification (a) (b) (c)		E. Object Class (a) (b) (c)		F. Amount	
										a. Date	
										b. Item	
										c. Amount	
										Gross Salary or Equip. Rental	
										Total →	
23. Remarks 08/04 Injured at 0130 08/08 Released from hospital, transported home.						24. ADO Check Number and Stamp					
NOTE: The above items are correct and proper for payment from available appropriations.						Gross Earning					
25. Employee Signature /s/ Jose Valdez						26. Time Officer (Signature) /s/ Carol Smith					
						Comn. Deduct.					
						Net Earning					

* Equipment rentals must be supported with OF-294 and OF-297

NSN 754-01-124-7633

OPTIONAL FORM 288 (Rev. 3/83)
 USDA/USDI
 50288-102

15.5 – Exhibit 09

SAMPLE INCIDENT INJURY CASE FILE ENVELOPE, OF-313

NAME OF CLAIMANT <i>Miller, Amy</i>	DATE OF INJURY OR ILLNESS <i>7/12/xxxx</i>	APMC []	OWCP [x]	FIRST AID ONLY []
INCIDENT/COMPLEX NAME <i>Warm Lake</i>	INCIDENT NUMBER <i>ID-BOD-005161</i>	UNIT LOG NUMBER M-		

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		
HCFA – 1500 – Health Insurance Claim Form	<i>7/12/xx</i>	
Follow-up Action Needed		

CLAIMANT ASSIGNED TO:

(Crew Name or OH Section)

CLAIMANT'S HOME UNIT: *BLM Boise District Office*
 (Agency)
3924 Development Ave.
 (Address)

Boise, ID 83705
 (City, State and Zip Code)
(208) 555-1212
 (Telephone No. with Area Code)

SUPERVISOR ON INCIDENT: *Laine Schwarberg*

SUPERVISOR'S HOME UNIT: *BLM Boise District Office*
 (Agency)

3924 Development Ave.
 (Address)

Boise, ID 83705
 (City, State and Zip Code)
(208) 555-1212
 (Telephone No. with Area Code)

*NOTE: **ORIGINAL** form must go to employee's home (or hiring) unit.

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

COMPENSATION FOR INJURY SPECIALIST/UNIT LEADER NAME <i>Sixel/Batey</i>	HOME UNIT TELEPHONE NUMBER (W/AREA CODE) <i>(208) 555-1212</i>	FINANCE/ADMIN SECTION CHIEF INITIALS <i>sg</i>
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