OBJECTIVE

This section provides direction on the roles of incident personnel in reporting and documenting injuries and illnesses on an incident, and authorizing medical treatment.

AUTHORITIES

There are 3 separate and distinct programs in this section, each with separate authorities. They are the federal workers’ compensation program; Agency Provided Medical Care (APMC) program and state workers’ compensation program.

RESPONSIBILITIES

Incident agency responsibilities:

- Ensure that appropriate federal and state workers’ compensation procedures outlined in this directive are implemented and followed.
- Provide a local contact and local guidelines/procedures for the Compensation/Claims Unit Leader (COMP).
- Providing local medical facility information.
- Establishing agreements or payment procedures with medical providers for APMC, if appropriate.

Incident Management Team (IMT) responsibilities:

- Provide appropriate and authorized medical attention to injured or ill individuals’.
- Forward claims per agency guidelines.
Finance/Administration Section Chief (FSC) responsibilities:

- Oversee the Compensation/Claims Unit to ensure appropriate injury/illness treatment, authorizations, documentation, and timely transmittal of information to the home unit.

- Ensure appropriate utilization of the APMC program and coordinating with the Medical Unit Leader (MEDL), medical providers, the incident agency, and others who may be involved.

Compensation/Claims Unit Leader or Compensation for Injury Specialist responsibilities:

- Ensure the appropriate state or federal forms are properly completed for all work related injuries or illnesses beyond first aid.

- Authorize medical treatment, as appropriate, using state workers’ compensation forms, form CA-16, Authorization for Examination or Treatment, or form FS-6100-16, APMC Authorization and Medical Report.

- Review medical treatment documentation for work restrictions and informing the individual’s supervisor of these restrictions.

- Ensure that necessary paperwork is completed, processed, forwarded and faxed to the individual’s home unit within established timeframes.

- Advise individuals’ of their rights and responsibilities when injured or ill.

- Provide information to the Time Unit Leader (TIME) for accurate posting of timesheets for injured/ill individuals’.

- Provide information to the TIME for payroll deduction of non-work related medical expenses.

- Follow up on the status of hospitalized or medical evacuated incident personnel.

- Inform FSC and Safety Officer of injury/illness and trends occurring on the incident.
Supervisor responsibilities:

- Obtain first aid/medical treatment for the injured person.
- Complete the supervisory portion of claim forms in a timely manner and giving receipt copy of the form to the injured person.
- Follow up with the Compensation/Claims Unit for work restrictions and follow-up medical treatment.
- Coordinate with the FSC and the Planning Section for work assignment modifications or recommendations for release from incident.
- Report time for injured/ill individual on a Crew Time Report (CTR).

Employee responsibilities:

- Request first aid or medical treatment if necessary.
- Notify supervisor of injury/illness.
- Complete employee portion of claim forms in a timely manner.
- Obtain witness statements.
- Promptly report time loss due to injury/illness to supervisor.

Home unit responsibilities:

- Follow applicable 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.
- Submit claims and medical documentation, as appropriate, to the appropriate workers’ compensation office in a timely manner.
- Handle all other case management responsibilities.
Definitions used throughout this handbook are located in Appendix C – Glossary.

First Aid – First aid is emergency care or treatment given to an ill or injured person before regular medical care can be obtained. First aid is generally provided by someone other than a physician. On incidents, most first aid is provided in the field or camp by medical unit personnel such as Emergency Medical Technicians (EMTs). First aid cases involve no lost time.

Examples of first aid treatment include cleaning, flushing, or soaking wounds on the skin surface; using wound coverings such as bandages; using hot or cold therapy; using any totally non-rigid means of support such as elastic bandages, wraps, non-rigid back belts; using temporary immobilization devices while transporting an accident victim such as splints, slings, neck collars, or back boards; using eye patches; using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye; using finger guards; drinking fluids to relieve heat stress.

Medical Care – Treatment including managing and caring for a patient for the purposes of combating disease or disorder. Care is generally provided by a physician.

Examples of medical care include examination of the injured employee, stitches, x-rays, medical tests such as blood work, surgery, hospitalization, etc.

Occupational Disease or Illness – A condition produced by the work environment over a period longer than a single workday or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment (20 CFR Subpart A, 10.5(q); Office of Workers Compensation Programs (OWCP) Publication CA-810, 2-3).

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. Any treatment by a nurse practitioner or physician’s assistant must be countersigned by a physician as defined in the previous sentence and in Department of Labor (DOL) Publication CA-810.
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Third-Party Case – 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. Contact the home unit for case management advice.

Submission Requirements – Incident personnel will fax and mail the original claim of injury or illness, along with supplemental information and medical documentation, to the home unit or agency specific location within 2 days.

Traumatic Injury – A wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable by time and place of occurrence and member of the body affected; it must be caused by a specific event or incident or series of events or incidents within a single day or work shift (20 CFR Subpart A, 10.5(ee); OWCP Publication CA-810, 2-2).

Federal Workers’ Compensation

The Federal Employees’ Compensation Act (FECA)

The FECA provides compensation benefits to civilian employees of the United States for disability due to personal injury or disease sustained while in the performance of duty. The FECA is the exclusive remedy for federal workers suffering a work related injury/illness. All related medical care including first aid; physician services; surgery; hospitalization; drugs and medicines; orthopedic, prosthetic, and other appliances and supplies are covered under the FECA. The U.S. DOL OWCP administers the FECA (20 CFR Part 10). OWCP has delegated agencies limited medical authorization authority through the proper use of form CA-16, Authorization for Examination and/or Treatment.

Coverage Under FECA

Included in coverage are civilian federal employees of the United States including those under a permanent, seasonal, temporary appointment, or casual hire. Those excluded from coverage include contractors and employees of contractors, inmate crews and their custodians, National Guard mobilized by a Governor's order and active duty military personnel.

Generally, federal employees are covered under FECA while in travel status away from their home unit unless they are engaged in non-work related activities or deviate from the authorized course of travel for personal reasons. In such cases, the individual may file a claim to obtain a determination from OWCP. Do not authorize medical treatment in these circumstances.

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Authorizing Medical Care

- **Traumatic Injuries** - OWCP has authorized agencies to issue form CA-16, Request for Examination and/or Treatment, to medical facilities/providers authorizing medical treatment for work related traumatic injuries. This form can only be issued once by the agency and provides for treatment up to 60 days, or until OWCP rules otherwise on the case. Issuance of the CA-16 allows the medical provider to refer the injured employee to specialists as necessary. CA-16 instructions direct the medical provider as to the type of treatment authorized and how to obtain further authorization from OWCP if necessary. The FSC, COMP, or the Injury Compensation Specialist (INJR) or other appropriate authorizing official may issue the CA-16 (Exhibit 16). The authorizing official shall ensure the appropriate U.S. DOL OWCP District Office address (based on the injured employee’s personal home mailing address) is indicated in block 12 of the CA-16 (Exhibit 17).

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

When there is doubt whether the injury is work related check block 6.B.2 of the CA-16 to let the physician know of the concern.

- **Occupational Disease or Illness** – OWCP rarely allows agencies to authorize medical treatment related to an occupational disease or illness. The employee is responsible for the cost of treatment and can file a claim (CA-2, Notice of Occupational Disease and Claim for Compensation) with OWCP for adjudication of the claim. Do not complete a CA-1, Federal Employee’s Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or issue a CA-16 for occupational disease or illness.

Continuation of Pay (COP)

- **Definition and Entitlement**. When a federal employee, including casuals, sustains a traumatic injury CA-1 is filed, (Exhibit 14) and seeks medical treatment from a physician, the individual may claim continuation of pay (COP) for any wage loss due to the injury. The intent of COP is to avoid interruption of the employee’s income while the claim is being adjudicated by OWCP. A disability exists only when
determined by the physician and time loss must be documented by medical records for an individual to be eligible for COP.

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. The individual is responsible to coordinate with their home unit for specific direction (20 CFR, Subpart B, 10.200 – 10.224; OWCP Publication CA-810, 5-1).

COP may not be paid after a termination date that was established prior to the injury. For casuals, COP ends when the casual leaves the incident, the original length of commitments ends, or when the casual is released back to duty, whichever occurs first.

There is no entitlement to COP for an occupational disease or illness.

- Controvert. In questionable situations, the agency may wish to controvert (not pay) COP. The instructions on the back side of the CA-1, item 36, identify the only reasons COP may be controverted. Any issues beyond those described should be communicated to the home unit for action.

- COP Recording Procedures. 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. COP begins with the first day of absence for disability or medical treatment following the date of injury and should be identified on the Emergency Firefighter Time Report, OF-288.

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 beginning the shift immediately following the 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 to the home unit from an incident assignment is considered work time and is not charged to COP.

Travel to and from a medical provider and/or time spent receiving medical treatment is compensable as work hours if it falls within the normal guaranteed work schedule (guaranteed 8 hour day for casuals). FECA does not allow payment of overtime for either of these activities.

COP Recording for Regular Government Employees

The COP rate for a regular government employee is determined by the individual’s home unit.

To record COP, indicate "COP" in the Start/Stop columns. Record, in the Hours column, 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 Hours column. Note date and time of injury and return to duty information in the Remarks block (Exhibit 20).

COP Recording for casuals

For casuals the COP rate is determined by the AD position classification the casual was working under at the time of injury.

To record COP, indicate “COP” in the Start/Stop columns and record “8” in the Hours column for each full day of disability. Indicate partial days of disability with clock hours and total COP hours in the Hours column. Note date and time of injury and related information in the Remarks block.
Example:

A PTRC (single resource) is injured on day 8 of a 14 day assignment, the disability continues for another 8 days, the PTRC would only be entitled to 6 days of COP.

A Type 2 crew member is injured on day 5 and released home. On day 10, the crew member was released by his physician to return to duty, but the rest of the crew completed the 14 day assignment. The crew member would only be entitled to 5 days COP. A casual is only entitled to COP, until released by a physician, not to exceed 45 days.

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 travel and medical treatment time), the COP entitlement would be 2 hours (4 hours work + 2 hours travel/medical + 2 hours COP = 8 hours guarantee). The 2 hours of medical time is compensable as work time as it falls within the guaranteed 8 hours. Record "COP" in the Start/Stop columns and "2" in the Hours column.

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.

Do not confuse COP with the guaranteed 8 hours per day for casuals. They are 2 different sets of guidance for entirely different purposes. For instance, COP is not allowed for an occupational disease or illness. However, if a casual has a cold and misses work, the casual may still be entitled to their guaranteed 8 hours of pay if not released from the incident.

Selection of Physician

Under FECA, employees may elect a physician of their choice. Emergency incidents that dictate securing medical services from the nearest available facility does not constitute selection or choice of physician. The election is still
available, should further treatment be necessary, when the employee returns to
the home unit.

**Agency Provided Medical Care (APMC)**

This is a program under which the agencies pay for limited costs for minor
injuries or illnesses that involve only one treatment. One possible follow up
visit is permissible if it occurs during non duty hours and the employee is
agreeable to this.

This coverage is separate from the provisions of the FECA. APMC should not
interfere with employee’s rights under FECA for treatment of work related
injuries and illness. Treatment under APMC may be disadvantageous to the
employee and the COMP/INJR is responsible to counsel the employee on their
options. Because OWCP has a fee schedule, costs associated with claims
through FECA are significantly lower than APMC treatment costs.

**Authority for APMC**

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 hazardous work. These authorities
should not be interpreted to circumvent OWCP procedures for FECA, which
provides the exclusive remedy for medical care and other benefits related to all
work-related injury or illness.

**APMC Coverage**

**Appropriate Use** – The use of APMC is appropriate for injury/illness cases
involving only 1 APMC visit which occurs on the day of the injury/illness. One
follow-up visit is permissible if it occurs during non-duty hours and the
employee is agreeable to this. APMC can only be used while the employee
remains at the site of the incident. Injury/illness cases treated under APMC
cannot have lost time charged to sick leave, annual leave, or (COP). If initial
treatment by a medical provider occurs after the date of injury, follow-up
treatment is necessary after the individual is released from the incident, and/or
lost time occurs or is expected, the claim must be processed under FECA.
Medical treatment for traumatic injury claims are most appropriately processed following the FECA procedures described earlier, rather than APMC procedures. This will establish a record for the employee with OWCP and provides the greatest protection and timely service should further treatment be necessary upon return to the home unit.

**Employee Choice of Processes** – Injured federal employees do not have a right to treatment under APMC as they do under FECA. It is the agency’s choice whether or not to offer APMC. Per OWCP, the employee’s use of APMC instead of FECA is voluntary. The COMP/INJR is responsible to counsel the employee on the difference between APMC and OWCP treatment and allow the employee to choose.

**APMC Use for Treatment of Traumatic Injuries** – Use of APMC for traumatic injuries must be limited to injury/illness cases involving only 1 treatment and may not include authorization for therapy, stitches, x-rays, or other non-first aid treatments.

**APMC Use for Treatment of Occupational Disease & Illness Claims** – APMC may be used to authorize first aid treatment only for illnesses such as respiratory infections, colds, sore throats and similar conditions associated with exposure to smoke, dust, and weather conditions, etc. Authorization of APMC treatment is at the discretion of the agency and should be minimal, only to relieve suffering. APMC is appropriate as an interim measure until the employee can arrange for private medical attention, at the individuals’ expense, or file a claim under FECA and await OWCP’s approval to incur medical expenses.

**Non-Work Related Injuries/Illness** – APMC should not be authorized for non-work related injuries or illnesses. However, in situations where it is deemed necessary by the incident agency, counsel the employee and ensure that a payroll deduction is made to cover the cost. 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.

**APMC Use for Dental Work** – Do not authorize APMC for dental treatment, e.g., toothache due to cavity, where there is any question whether it relates to a work related injury. Upon return to the home unit, the individual can obtain treatment and file a claim for reimbursement from OWCP if they feel the condition was work related. However, in situations where it is deemed necessary by the incident agency, counsel the employee and ensure that a payroll deduction is made to cover the cost.
Contractors – Contract personnel may not utilize APMC services.

State and Other Non-Federal Employees – State authorities vary and may not allow APMC for state employees. The sending unit geographic area state or federal incident business management coordinator should be contacted for the states policy in this matter if the injured individual does not have the information (State and National Guard employees’ coverage is dependent on the contract and/or agreement under which they are dispatched).

Military Personnel – Military medical units will provide treatment for military personnel (Military Use Handbook, Chapter 100).

Procedures to Establish APMC

The FSC coordinates the establishment of APMC through the incident agency.

Payment of APMC Costs

Appropriate APMC costs, as authorized by the FSC or COMP, are paid by incident personnel or the incident agency per agency policy.

Procedures for Using APMC

Medical Resource Request Number – A medical resource request number (M#) is assigned for treatment under APMC. The M# is issued to the medical provider by the Finance/Administration Section. Requests 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 “076” is the sequential incident number. 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#. One M# is issued to cover APMC treatment associated with a specific injury or illness.

COMP or INJR issues the APMC Authorization and Medical Report, Form FS-6100-16, which is used to authorize APMC treatment and for the medical provider to document patient evaluation and diagnosis. The FS-6100-16 is returned to the COMP/INJR so duty status and disability determinations can be made.

All APMC cases must have the M# entered on the top of all reporting forms with a notation “Paid by APMC”.

Release Date: August 2012
All authorized services must be summarized on the Incident Injury/Illness Log. The FSC/COMP provides a copy of the log to the incident agency to support payment for APMC and to facilitate follow-up (Exhibit 19).

Do not confuse APMC procedures with either state or federal workers' compensation programs. Do not issue a form CA-16, Authorization for Examination and Treatment for APMC.

### Procedures and Documentation Requirements for FECA or APMC

#### Traumatic Injury

**Form Required** – CA-1, Report of Traumatic Injury and Claim for Compensation.

**Action Taken:**

- Individual completes the front of form as soon as possible and preferably within 48 hours of the injury. Supervisor completes the reverse side, signs, and gives receipt to individual.

- Individual/supervisor should obtain witness statement(s) if appropriate. Supervisor is responsible for completion if employee is incapacitated.

- Leave blocks titled “Occupational code”, “Type code”, “Source code”, “OWCP Agency Code”, and “Occupational Safety and Health Administration (OSHA) Site Code” blank. Home unit is responsible to complete.

- INJR advises individual of rights, benefits, and responsibilities.

- INJR authorizes medical care, if appropriate, by issuing:
  - If using FECA procedures: CA-16, Authorization for Examination and/or Treatment, if the case requires any medical treatment. Only 1 form per injury is issued to the medical provider. **OR**;
  - If using APMC procedures: FS-6100-16, APMC Authorization and Medical Report for 1 first aid type of treatment. If a follow-up appointment, after duty hours, is
required, INJR issues another FS-6100-16. The original M number is used for a follow up visit.

- If verbal authorization is given to the medical provider, forward the authorization form to provider within 48 hours.

  o Injured individual or individual acting on their behalf returns completed form to the INJR.

  o COMP/INJR faxes and mails original injury/illness forms, supporting documentation and medical treatment records to the individual’s home unit compensation specialist within 2 days of receipt of the CA-1.

**Occupational Disease (Illness)** covered by FECA requiring medical treatment or resulting in lost time.

**Form Required** – CA-2, Notice of Occupational Disease and Claim for Compensation.

**Action Taken:**

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

  o Leave blocks titled “Occupational code”, “Type code”, “Source code”, “OWCP Agency Code”, and “OSHA Site Code” blank. Home unit is responsible to complete.

  o INJR advises individual of rights, benefits, and responsibilities.

  o INJR authorizes appropriate APMC medical care, using a FS-6100-16, for first aid treatment for illnesses such as respiratory illness, colds, sore throats and similar conditions associated with exposure to smoke, dust, and weather conditions, etc. Treatment of more significant illness/disease conditions are not authorized and must be submitted to OWCP for adjudication. Do not issue a CA-16 for an occupational disease or illness.
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- COMP/INJR faxes and mails original injury/illness forms, supporting documentation and medical treatment records to the individual’s home unit compensation specialist within 2 days of receipt of the CA-2.

**Prescriptions** – Utilize local pharmacies that accept the DOL, OWCP fee schedule and bill directly. Pharmacies/Medical providers not enrolled with DOL, OWCP, Division of Federal Employees Compensation (DFEC), should contact DOL, Affiliated Computer Services (ACS) https://owcp.dol.acs-inc.com.

**Fatality** – The individual’s home unit processes workers’ compensation claim. If death is not immediate incident finance personnel takes the following actions;

- **Forms Required** – If death is not immediate
  - CA-1, Report of Traumatic Injury and Claim for Compensation
  - CA-16, Authorization for Examination and/or Treatment, if appropriate

- **Action Taken:**
  - COMP/INJR authorizes medical care, as appropriate under FECA regulation, utilizing the CA-16, Authorization for Examination and/or Treatment, if employee is transported to medical facility to be treated before death is declared. (CA-16’s should not be issued for any type of illness or injury that, even though life-threatening, is not clearly work related. Seizures, chest pains, stroke symptoms, or unexplained loss of consciousness are not clearly work related, and a CA-16 should not be issued).
  - Supervisor completes the front and back of the CA-1 form as soon as possible.
  - COMP/INJR faxes all forms and supporting documentation (medical reports, accident investigation report, witness statements, etc.) to the home unit immediately upon receipt, and mails original injury/illness forms, supporting documentation to the individual’s home unit compensation specialist within 2 days of receipt.
Federal agencies are required to submit workers’ compensation claims documents to OWCP within 10 days of the date signed by the employee. In order for home units to comply, the COMP/INJR faxes and mails original injury/illness forms, supporting documentation and medical treatment records to the individual’s home unit compensation specialist within 2 days of receipt of the CA-1/CA-2. This allows the home unit to review the information, contact the incident if clarification is necessary, meet OWCP reporting requirements and ensure injured workers receive timely and quality service. A temporary copy may be retained by the Compensation/Claims Unit during the incident, but must be either sent home with the employee or destroyed prior to the end of the incident.

The Compensation/Claims Unit Leader:

- Uses the Incident Injury Case File Envelope to file injury forms, supporting documentation, and medical treatment documentation. Forward the complete package to the individual’s home unit upon demobilization of the individual (Exhibit 22).

- Completes an Incident Injury/Illness Log to document injuries/illnesses. The log may not contain any sensitive information (Exhibit 19).

**All compensation for injury documents are protected by the Privacy Act and shall not be retained in the incident records.** When original documents are forwarded to the home unit or other location as specified, all temporary copies are sent home with the employee or destroyed. Retain the Incident Injury/Illness Log in the incident records.

**State and Cooperators Workers’ Compensation Coverage**

- **State Workers’ Compensation** – State employees experiencing injury or illness on the incident should complete state specific forms and notify their home unit of workers’ compensation claims per agency requirements. If state forms are not available, the employee may use a CA-1 or CA-2 to initially record the necessary information. Federal references should be crossed out and the state name written at the top of the form. The state employee is responsible to contact the home unit to obtain the proper reporting forms. The COMP maintains injury compensation records and transmits documents to the home unit per
state agency policy. Do not issue CA-16 for medical treatment. Reference APMC coverage.

- **Cooperators** – Cooperators are normally covered under their home unit workers’ compensation program, e.g., state, county, local government. Cooperators experiencing injury or illness on the incident should complete home unit specific forms and notify their home unit of workers’ compensation claims per their agency requirements. The COMP maintains injury compensation records and transmits documents to the home unit per cooperator agency policy.

If a cooperator is hired as a federal casual, follow FECA or APMC procedures as appropriate. If a cooperator is hired as a state employee, follow state workers’ compensation procedures.

Federal agencies entering into cooperative agreements do not have the authority to grant FECA coverage to individual cooperators. Some cooperative agreements require reimbursement for medical costs. This should not be interpreted as providing coverage under FECA.

**EXHIBITS**

- Exhibit 14 – Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (CA-1)
- Exhibit 15 – Notice of Occupational Disease and Claim for Compensation (CA-2)
- Exhibit 16 – Authorization for Examination and/or Treatment (CA-16)
- Exhibit 17 – U.S. Department of Labor OWCP District Offices List
- Exhibit 18 – Agency Provided Medical Care (APMC) Authorization and Medical Report (FS-6100-16)
- Exhibit 19 – Sample Incident Injury/Illness Log
- Exhibit 22 – Sample Incident Injury Case File Envelope (OF-313)
EXHIBIT 14
NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION, CA-1

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

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

1. Name of employee (Last, First, middle)  
Smith, Katrina L

2. Social Security Number  
006-00-0000

3. Date of Birth (Mo. Day Yr.)  
XX/XX/XX

4. Sex  
Female

5. Address Telephone (Include area code)  
208-555-1234

6. Grade and date of hire

7. Employment Agency (unless no Compensation Specialist) Complete shaded boxes a, b, and c.

a. Date of hire  
07/12/2008

b. Employer's home mailing address (include city, state, and zip code)  
123 Waterway Rd

Boise, ID 83705

c. Description of Injury  
Warm Lake Incident Base - Tool Sharpening Area

8. Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th Floor)

9. Nature of Injury (Describe what happened and why)  
While sharpening a shovel, my hand slipped and my right thumb ran across the shovel's edge.

10. Date Injury Occurred (Mo. Day Yr.)  
07/12/2008

11. Time (a.m. or p.m.)  
10:15

12. Employer's Occupation  
Forestry Technician

13. Claim 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

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. I have injured myself or another person, nor by my intoxication, nor by the negligence of any physical or natural person. I have attached all medical records, if needed, and the following as checked below, which disabled me for work:

a. Certification of regular pay (COP) dated no earlier than 45 days and compensation for wage loss if disability the week continues beyond 45 days. If my claim is denied, I understand that the continuation of any regular pay shall be charged to sick or invalid leave, or be declared an overpayment within the meaning of 5 USC 8381.

b. Information on spread and Annual Leave.

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

Employee Signature  

Signature of a person or persons acting as authorized by the employee's superior

Date  
07/12/2008

Witness Statement

I was working beside Katrina L and I saw her cut her right thumb on a shovel edge.

Witness's Signature  
Piper Lynn

Address  
PO Box 3333

City  
Boise

State  
ID

Zip Code  
83704

Date  
07/12/2008

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### EXHIBIT 14 - Continued

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

**Supervisor's Report**

1. Agency name and address of reporting office (include city, state, and zip code)
   - OSHA Site Code
   - Agency name

2. BLM - Boise District Office
   - Boise ID 83705
   - 3924 Development Avenue
   - OSHA Site Code
   - Agency name

3. Employee's name:
   - ID 83705
   - 3924 Development Avenue
   - Other

4. Employee's retirement coverage
   - CSRS
   - FERS
   - Other (identify)

5. Regular work hours:
   - From: 08:00 am
   - To: 05:00 pm

6. Regular work schedule
   - Sun.
   - Mon.
   - Tues.
   - Wed.
   - Thurs.
   - Fri.
   - Sat.

7. Date of injury:
   - 07/12/2008
   - 07/12/2008

8. Date notice received
   - 07/12/2008
   - 07/12/2008

9. Date work stopped
   - 07/12/2008
   - 07/12/2008

10. Date work returned to
     - 07/14/2008
     - 07/14/2008

11. Was employee injured in performance of duty? Yes ☑ No ☐

12. Was injury caused by employer's willful misconduct, negligence, or fault to injure self or another? Yes ☐ No ☑

13. Was injury caused by a third party? Yes ☐ No ☑

14. Name and address of third party

15. Name and address of physician first providing medical care
   - ID 83705
   - 3924 Development Avenue
   - Boise ID 83705

16. First date medical care received
   - 07/12/2008

17. Did medical reports show employee is disabled for work? Yes ☑ No ☐

18. Did the employing agency controvert continuation of pay, state the reason in detail.

19. Pay rate when employee stopped work
   - $ 17.70 per hour

20. Signature of supervisor and filing instructions

   a. 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:

   b. Name of supervisor (Type or print)
   - Lailie Schwartzenberg

   c. Signature of supervisor
   - Date 07/12/2008

   d. Supervisor's Title
   - Office phone (208) 555-1213

   e. Supply Unit Leader

   f. Filing instructions
   - No lost time and no medical expense; Place this form in employee's medical folder (SF 411-D)
   - Lost time covered by leave, LWCP, or COIP; forward this form to OSHA.

**Form CA-1**

**Rev. Apr. 1999**

**Release Date:** August 2012

**10-105**
EXHIBIT 14 - Continued

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.

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.

### 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.

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 premise” duties;

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

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

g) Work stoppage first occurred 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.
EXHIBIT 15
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

Employee Information

1. Name of employee: (Last, First, Middle)
   Rusty, Tim B.

2. Social Security Number
   000-00-0000

3. Date of birth
   3-17-59

4. Home telephone
   (209) 556-1111

5. City
   Boise

6. State
   ID

7. Zip code
   83705

Claim Information

8. Occupation
   Forestry Technician

9. Location (address) where employee worked when disease or illness occurred (include city, state, and zip code)
   1275 Cedarwood Road

10. Date you last worked
    8-22-81

11. Date you first noticed that disease or illness may have been caused by your employment
    8-22-81

While working as a firefighter on the Boise Fire, I was subjected to a great amount of smoke inhalation. The smoke was caused by a brush fire in the area where I was working.

12. Nature of disease or illness
    Smoke Inhalation

13. Compensation Code
    330000

14. Date of separation
    8-22-81

15. Date of last medical examination
    8-22-81

16. Date of death
    8-22-81

17. Date of last payment
    8-22-81

Employee Signature

Rusty Tim B.

Date
8-22-08

Release Date: August 2012
**EXHIBIT 15 - Continued**

### Official Supervisor's Report of Occupational Disease

<table>
<thead>
<tr>
<th>Table Heading</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Name and address of reporting office (include city, state, and ZIP code)</td>
<td>USFS, ASC-CHC Workers' Compensation Section</td>
</tr>
<tr>
<td><strong>B.</strong> Address of employer</td>
<td>3500 Marshfield St., MS-11B</td>
</tr>
<tr>
<td><strong>C.</strong> Name of employee</td>
<td>John Doe</td>
</tr>
<tr>
<td><strong>D.</strong> Date of injury</td>
<td>08/22/2008</td>
</tr>
<tr>
<td><strong>E.</strong> Time of injury</td>
<td>08:00 AM</td>
</tr>
<tr>
<td><strong>F.</strong> Date of first medical care received</td>
<td>08/23/2008</td>
</tr>
<tr>
<td><strong>G.</strong> Time of first medical care received</td>
<td>08:00 AM</td>
</tr>
</tbody>
</table>

### Medical Condition

- **Symptoms:** Headache, Fatigue
- **Medical Treatments:** Over-the-counter analgesics, rest

### Occupation and Industry

- **Industries:** Logging, Trucking
- **Occupation:** Log Driver

### Injury Details

- **Injury Type:** Overexertion
- **Disability:** Partial

### Signature and Certification

- **Supervisor's Signature:** [Signature]
- **Date:** 08/22/2008
- **OCC-19907 Form:** Rev. Jan. 1990

---

Release Date: August 2012
EXHIBIT 16
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 regulations for this information are published in 29 CFR 1001-1021. The regulations prohibit disclosure of any personal information collected under this program unless that information is released to another federal agency for purposes of collecting, maintaining, and publishing injury statistics. The regulations also require that information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, and OWCP's Privacy Act program.

UWCP No.: 1215003
Exhibit: 90 36 51

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:
DR. Stevenson
1231 Water Street
Dover, ID 83710

2. Employee's Name (last, first, middle):
Miller, Amy K.

3. Date of Injury (y, m, d, w):
7/12/104

4. Occupation:
Forestry Technician

5. Description of Injury or Disease:
Right Thumb Laceration

6. You are authorized to receive medical care for this employee for a period of up to sixty days from the date shown in item 8, subject to the condition stated in item A, and to the conditions indicated in 1 or 2, if necessary.

A. Your signature in item 3 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 such services.

B. If your medical facility or hospital as its necessity for the effects of the injury. Any surgery other than emergency must have your OWCP approval.

C. 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 their standard 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. Further advice you may provide necessary examination treatment if you believe the condition may be the injury or to the employment.

7. If the Disease or Injury is Multiple, "OWCP" Approve for all Conditions.

Authorization was obtained from:
(Upon Name and Title of OWCP Office)

8. Signature of Authorizing Official:

Siskel Bailey
Director/Chief Unit Leader

9. Name and Title of Authorizing Official (Type of proffer)

10. Local Unemployment Agency Telephone Number:
(208) 555-0120

11. Date (m, d, y, year):
7/12/104

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
1911 Third Avenue, Suite 650
Seattle, WA 98101-5212

Department or Agency:
U.S. Department of Interior

Bureau of Office

Bureau of Land Management

Local Address (Including Zip Code):
3624 Development Avenue
Boise, ID 83705

(Note: Exhbit O4 for OWCP District Office list)

Public Funding Statement

Public funding for this collection of information is estimated to take 20 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, Department of Labor, Room N1310, 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.
## Exhibit 17
### US Department of Labor OWCP District Offices

**US Department of Labor District Offices**

<table>
<thead>
<tr>
<th>District Office 1 – Boston</th>
<th>District Office 11 – Kansas City</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) U.S. Dept. of Labor, OWCP JFK Federal Building, Room E-260 Boston, MA 02203</td>
<td>(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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Office 2 – New York</th>
<th>District Office 12 – Denver</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>District Office 3 – Philadelphia</th>
<th>District Office 13 – San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Delaware, Pennsylvania, and West Virginia; Maryland when the claimant's residence has a zip code beginning with 21***) U.S. Dept. of Labor, OWCP Curtis Center, Suite 715 East 170 S. Independence Mall West Philadelphia, PA 19106-3308</td>
<td>(Arizona, California, Hawaii, and Nevada) U.S. Dept. of Labor, OWCP 90 Seventh St., Suite 15300 San Francisco, CA 94103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Office 6 – Jacksonville</th>
<th>District Office 14 – Seattle</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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</td>
<td>(Alaska, Idaho, Oregon, and Washington) U.S. Dept. of Labor, OWCP 300 Fifth Avenue, Ste 1050 Seattle, WA 98104</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Office 9 – Cleveland</th>
<th>District Office 16 – Dallas</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Indiana, Michigan, Ohio; All special claims and all areas outside of the U.S., Its possessions, territories and trust territories) U.S. Dept. of Labor, OWCP 1240 East Ninth Street, Room 851 Cleveland, OH 44199</td>
<td>(Louisiana, Oklahoma, and Texas) U.S. Dept. of Labor, OWCP 525 South Griffin Street, Room 100 Dallas, TX 75202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Office 10 – Chicago</th>
<th>District Office 25 – Washington D.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Illinois, Minnesota, Wisconsin) U.S. Dept. of Labor, OWCP 230 South Dearborn Street, Eighth Floor Chicago, IL 60604</td>
<td>(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. Capital Street N.W., Room 800 Washington, D.C. 20211</td>
</tr>
</tbody>
</table>
EXHIBIT 18
AGENCY PROVIDED MEDICAL CARE (APMC) AUTHORIZATION
AND MEDICAL REPORT, FS-6100-16

USDA Forest Service

AGENCY PROVIDED MEDICAL CARE AUTHORIZATION AND MEDICAL REPORT
(Physician or Medical Facility Form may be used for Medical Report)
(Refer to FSH 5109.34, NBMH Chptr 10)

Part A Authorization

1. Medical Resource Request "M Number"
   M-2

2. Procurement Identification (SPA/Field PO No., etc)

3. Responsible Payment Unit
   Boise National Forest

4. Employee Name
   Tim Ruby

5. Social Security No.
   XXX-XX-XXXX

6. Employing Agency
   Forest Service, Boise National Forest

7. Home Unit and Address
   Boise National Forest
   1275 Oakwood Road
   Boise, ID 83704

8. Date of Injury
   08/22/XXXX

9a. Description of Injury or Disease:

   Smoke Inhalation

   Please provide initial diagnosis and treatment medically necessary for injuries. Surgery, other than emergency, and/or hospitalization required further authorizations. 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. or Officer, FSC, or COMMP)
    Cascade Corp.
    COMMP

Part B Attending Physician's Report

1. Evaluation or Diagnosis:
   Smoke Inhalation resulting in a bronchial infection

2. Description of Treatment:
   Bronchial therapy and medication

3. Medical 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
   Doctor Signature, MD

   Date
   08/22/XXXX

Attachment: Employee's CA-1/CA-2 (white copy)
Medical Facility CA-1/CA-2 (pink copy)
Incident Unit 12/1, area CA-1/CA-2 (yellow copy)
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 four 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 Headquarters' Compensation Specialist:

<table>
<thead>
<tr>
<th>Comp Specialist Name</th>
<th>Connie Comp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Unit Headquarters</td>
<td>R4 USFS</td>
</tr>
<tr>
<td>Phone Number</td>
<td>(XXX) XXX-XXXX</td>
</tr>
</tbody>
</table>
EXHIBIT 19
SAMPLE INCIDENT INJURY/ILLNESS LOG

<table>
<thead>
<tr>
<th>INCIDENT NUMBER</th>
<th>INCIDENT NAME</th>
<th>EMPLOYEE NAME</th>
<th>HOME UNIT &amp; PHONE</th>
<th>DATE OF INJURY</th>
<th>SUPERVISOR NAME</th>
<th>HOME UNIT &amp; PHONE</th>
<th>FORMS PREPARED</th>
<th>NATURE OF INJURY/ILLNESS</th>
<th>DATE WORKS REHABILITATED TO RETURN TO WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>John Smith</td>
<td>Jane Doe</td>
<td>HR</td>
<td>7/12/2000</td>
<td>Mr. Clark</td>
<td>Admin</td>
<td>N/A</td>
<td>Right-Hand Infection</td>
<td>7/12/2000</td>
</tr>
</tbody>
</table>

This is a sample incident injury/illness log. It includes columns for incident number, incident name, employee name, home unit & phone, date of injury, supervisor name, home unit & phone, forms prepared, nature of injury/illness, and date works rehabilitated to return to work.
EXHIBIT 20
EMERGENCY FIREFIGHTER TIME REPORT (OF-288) SHOWING COP FOR A REGULAR FEDERAL EMPLOYEE

<table>
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<tr>
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<tbody>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>07/13/08</td>
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<td>Warm Lake</td>
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</table>

Total Hours: 10.0

Time Report: 07/11/08 to 07/13/08

In Case of Emergency Notify:
Sue Bear
118 W Smokey Bear Blvd
Boise, ID 83705

Release Date: August 2012
### EXHIBIT 21

**EMERGENCY FIREFIGHTER TIME REPORT (OF-288) SHOWING COP FOR A CASUAL**

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Total Time</td>
</tr>
<tr>
<td>08/01</td>
<td>09:00</td>
<td>23:56</td>
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<td>08/04</td>
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<td>08:00</td>
<td>1:50</td>
</tr>
</tbody>
</table>

**Total Hours:** 24.00

**NOTES:**
- Unpaid time not covered by the City on a payroll basis.
- Time off is approved by the Mayor.

---

**EMERGENCY FIREFIGHTER TIME REPORT**

**F711**

- **Ward:** Warm Lake
- **Fire Location:** Warm Lake
- **Station:** 209

**Emergency Firefighter Time Report (OF-288)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01</td>
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<td>23:56</td>
</tr>
<tr>
<td>08/04</td>
<td>15:00</td>
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</tr>
<tr>
<td>08/07</td>
<td>08:00</td>
<td>1:50</td>
</tr>
</tbody>
</table>

**Total Hours:** 24.00

**NOTES:**
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**EMERGENCY FIREFIGHTER TIME REPORT**

**F711**

- **Ward:** Warm Lake
- **Fire Location:** Warm Lake
- **Station:** 209

**Emergency Firefighter Time Report (OF-288)**

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>08/01</td>
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<td>4:00</td>
</tr>
<tr>
<td>08/07</td>
<td>08:00</td>
<td>1:50</td>
</tr>
</tbody>
</table>

**Total Hours:** 24.00

**NOTES:**
- Unpaid time not covered by the City on a payroll basis.
- Time off is approved by the Mayor.

---

**EMERGENCY FIREFIGHTER TIME REPORT**

**F711**

- **Ward:** Warm Lake
- **Fire Location:** Warm Lake
- **Station:** 209

**Emergency Firefighter Time Report (OF-288)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01</td>
<td>09:00</td>
<td>23:56</td>
</tr>
<tr>
<td>08/04</td>
<td>15:00</td>
<td>6:50</td>
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<tr>
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<td>06:00</td>
<td>8:30</td>
</tr>
<tr>
<td>08/06</td>
<td>19:00</td>
<td>4:00</td>
</tr>
<tr>
<td>08/07</td>
<td>08:00</td>
<td>1:50</td>
</tr>
</tbody>
</table>

**Total Hours:** 24.00

**NOTES:**
- Unpaid time not covered by the City on a payroll basis.
- Time off is approved by the Mayor.
<table>
<thead>
<tr>
<th>NAME OF CLAIMANT</th>
<th>DATE OF INJURY OR ILLNESS</th>
<th>APMC</th>
<th>OWCP</th>
<th>FIRST AID ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miller, Amy</td>
<td>7/12/xxxx</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INCIDENT/COMPLEX NAME**

<table>
<thead>
<tr>
<th>INCIDENT NUMBER</th>
<th>UNIT LOG NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID-BOD-005161</td>
<td>M-</td>
</tr>
</tbody>
</table>

**CLAIMANT ASSIGNED TO:**

(Crew Name or OH Section)

**CLAIMANT'S HOME UNIT:**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Address</th>
<th>City, State and Zip Code</th>
<th>Telephone No. with Area Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLM Boise District Office</td>
<td>3924 Development Ave</td>
<td>Boise, ID 83705</td>
<td>(208) 555-1212</td>
</tr>
</tbody>
</table>

**SUPERVISOR ON INCIDENT:**

Laine Schwarberg

**SUPERVISOR'S HOME UNIT:**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Address</th>
<th>City, State and Zip Code</th>
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<td>3924 Development Ave</td>
<td>Boise, ID 83705</td>
<td>(208) 555-1212</td>
</tr>
</tbody>
</table>

**CHECK LIST FOR CASE FILES**

(Indicate Whether Completed)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>*CA-1 – Report of Injury</td>
<td>7/12/xx</td>
</tr>
<tr>
<td>*CA-2 – Report of Illness</td>
<td></td>
</tr>
<tr>
<td>CA-16 Request for Examination and/or Treatment</td>
<td>7/12/xx</td>
</tr>
<tr>
<td>FS-6100-16 – Agency Provided Medical Care Authorization and Medical Report</td>
<td></td>
</tr>
<tr>
<td>CA-17 – Duty Status Report</td>
<td></td>
</tr>
<tr>
<td>HCFA – 1500 – Health Insurance Claim Form</td>
<td>7/12/xx</td>
</tr>
</tbody>
</table>

Follow-up Action Needed

*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.