

Seeking Immediate Medical Attention for Your Work-Related Injury

All work-related injuries and illnesses involving federal employees, equipment, or facilities must be reported to the Ms. Anastasia Williams after the injury or illness has been reported through your supervisory channels. Anastasia can be reached at 301-504-1471 or by email at anastasia.williams@ars.usda.gov. If Anastasia is not available then you can contact Ms. Tamara McKinney at 301-504-1449 or tamara.mckinney@ars.usda.gov.

Life-Threatening Injuries: Call 911. If possible, find someone who is First Aid/CPR/AED certified to assist the victim until the ambulance arrives. Send someone else to retrieve an AED kit in-case it is needed. Contact the supervisor, RL, and Anastasia as soon as possible.

Non Life-Threatening Injuries:

- It is **CRITICAL** for you to inform the medical provider that ***you are a federal employee*** and that the injury occurred while ***on the job!***
- If seeking medical treatment **within 48 hours** of the injury your supervisor may authorize guaranteed reimbursement for your medical treatment by filling out a CA-16. The **CA-16 must accompany you** to the physician. This document is attached. *You may seek treatment without a CA-16 but you will be responsible for covering the expense if the Department of Labor (DOL) rejects your claim.*
 - **NOTE:** Whenever a physician determines there is no injury present the DOL will **always reject your claim**. Therefore, a **CA-16 is critical** when seeking a post-accident check-up, even if no injury is suspected. Otherwise you will not be reimbursed for this preventative visit.
- Please provide the physician with *Instructions on How to File a Workers Compensation Claim for ARS Corvallis Employees*. This document is attached (see third page).
- Have someone else, preferably the supervisor, drive you. Call ahead (en-route).
- Have an MSDS or other product information if the injury was a chemical over-exposure.
- Your physician must provide you a form that specifies the following information:
 - When you will be able to return to work.
 - What your work restrictions are.
- If you are not completely restricted from returning to work **you must report to work the following day.**
- Within 30 days of the injury but preferably as soon as possible you and your supervisor must complete a CA-1. This document is attached and can also be found here: www.dol.gov/owcp/regs/compliance/ca-1.pdf
- Call Anastasia for assistance with this paperwork.

You are entitled to select any physician or facility of your choosing to provide treatment. However, the selected provider must meet the definition of physician under the Federal Employee's Compensation Act. Typically chiropractors or non-traditional healers are not considered acceptable care providers. **It is highly recommended** that you visit your primary physician or another physician that is covered by your insurance. This will help protect you financially if the Department of Labor rejects your claim for workers compensation.

Once you have selected a physician you must continue to see them for any follow-up exams or treatments that are related to your injury. If you wish to change physicians additional paperwork is required (call Anastasia). DOL will also cover reasonable injury-related exams or treatments by different specialists (physical therapy, orthopedics, etc.) on the condition that your initial physician referred you to these specialists.

You must provide a copy of your physician-directed work restrictions to your supervisor as soon as possible. If your physician has cleared you to return to work, even if in a limited capacity, your supervisor may request that you still report to work to perform duties that you are medically cleared for. To not report to work without the prior approval from your supervisor is considered an absence without leave.

If your injury causes you a temporary disability and you are unable to work in any capacity you must provide the Agency, through your supervisor, with medical justification within 10 days to claim continuation of pay (COP). In most cases, the COP will pay your full salary for up to 45 days of absence from work while you recover enough to return to work.

Non-Federal Cooperators: Non-federal cooperators, who are employed by their sponsor organization and engaged in activities that benefit their employer, are typically not entitled to medical treatment through the Federal Employees Compensation Act (FECA), should they be injured while working on ARS projects. Federal funds may not be expended for resulting medical expenses. The cooperator would need to seek treatment through their employer's worker's compensation insurance. The ARS employee who coordinates the work for the cooperator is responsible for reporting the injury to the cooperator's organization and for requesting immediate medical attention in an emergency.

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

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

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

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data							
1. Name of employee (Last, First, Middle)						2. Social Security Number	
3. Date of birth Mo. Day Yr.		4. Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		5. Home telephone		6. Grade as of date of injury Level <input type="checkbox"/> Step <input type="checkbox"/>	
7. Employee's home mailing address (include street address, city, state, and ZIP code)						8. Dependents	
City						Wife, Husband <input type="checkbox"/>	
State						Children under 18 years <input type="checkbox"/>	
ZIP Code						Other <input type="checkbox"/>	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.		Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		11. Date of this notice Mo. Day Yr.		12. Employee's occupation	
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13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)			a. Occupation code
			b. Type code
			c. Source code
			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 5584.

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 _____ Date _____

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)

Name of witness	Signature of witness	Date signed
Address	City	State
	ZIP Code	

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

Supervisor's Report

17. Agency name and address of reporting office (include street address, city, state, and ZIP code) OWCP Agency Code

 OSHA Site Code

City State ZIP Code

18. Employee's duty station (include street address, city, state, and ZIP code) City State ZIP Code

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

20. Regular work hours From: a.m. To: a.m.
 p.m. p.m.

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

22. Date of Injury Mo. Day Yr.
23. Date notice received Mo. Day Yr.
24. Date stopped work Mo. Day Yr. Time: a.m. p.m.

25. Date pay stopped Mo. Day Yr.
26. Date 45 day period began Mo. Day Yr.
27. Date returned to work Mo. Day Yr. Time: 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 32.)

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

 City State ZIP Code

32. Name and address of physician first providing medical care (include street address, city, state, ZIP code)

 City State ZIP Code

33. First date medical care received Mo. Day Yr.
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 witnesses? Yes No (If "No," explain)

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

37. Pay rate when employee stopped work
\$ Per

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:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

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

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 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.

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 defringement 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)

[Redacted Name]

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

[Redacted Date]

At (Location)

[Redacted Location]

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

[Redacted Title]

[Redacted Date]

**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:

2. Employee's Name (last, first, middle)	3. Date of Injury (mo., day, yr.)	4. Occupation
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5. Description of Injury or Disease:

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. 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.
- 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)

10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
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<p>12. Send one copy of your report: (Fill in remainder of address)</p> <p>U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs</p>	<p>13. Name and Address of Employee's Place of Employment:</p> <p>Department or Agency</p> <p>Bureau or Office</p> <p>Local Address (Including Zip Code)</p>
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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 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.

Injured Employees: Please provide this page to your attending clinic or hospital

How to Handle a Federal Workers Compensation Claim for a USDA ARS Employee

Federal Workers Compensation claims are handled differently than state claims. Furthermore, United States Department of Agriculture (USDA) Agricultural Research Service (ARS) claims are handled a little differently than other Federal agencies.

How to Establish the Worker's Claim: The instructions listed on Federal claims forms are insufficient. Initial workers compensation claims for Federal employees **should not** be sent directly to the Department of Labor (DOL) because, without a claim number, the DOL is unable to process the paperwork. A claim number is **only established** when the worker's supervisor submits a CA-1 to DOL.

The most effective way to expedite the payment process is to route the initial medical paperwork through the USDA ARS Agency to DOL. We will couple it with additional, in-house, paperwork (like the CA-1) and send it as package, through official channels, to DOL.

For employees who work for USDA ARS in Corvallis: Paperwork, to include charts and notes, should be faxed or otherwise sent to the contact below:

Anastasia Williams
Workers' Compensation Specialist
USDA, ARS, HRD, OWCP
5601 Sunnyside Avenue
Mailstop 5101, Room 3-1108D
Beltsville, MD 20705-5101
Phone: 301-504-1471
Fax: 301-504-1540
Email: Anastasia.Williams@ars.usda.gov

The employee may ask you to fill out a CA-20, *Attending Physicians Report* or, on initial visits, the reverse side of the CA-16, *Authorization for Examination And/Or Treatment*. The CA-20, along with other pertinent forms, can be found here:

<http://www.dol.gov/owcp/dfec/regs/compliance/forms.htm>

These forms are not required for medical documentation. The physician narrative or clinic-specific form is acceptable in-lieu of the CA-20. However, the forms must have sufficient information for DOL to make a determination on the claim. Primarily, **we need the following information to be very cut and clear:**

- The cause of the injury must be causally linked to factors present in the workplace.
- It must be specified when the worker will be able to return to full or partial duty.
- It must be specified what work restrictions will be placed on the worker during their recovery.

Please do not include any medical information that is not directly related to the work-place injury. In respect to the privacy of our employees we are only interested in information that will help us

establish the claim with DOL and to determine an appropriate work schedule during their recovery. Please use our forms if you are uncertain about what information is relevant and should be included and what information is private medical information and shouldn't be reported to us.

How to Handle Bills:

Bills will not be paid until DOL establishes a claim number. Any bills sent to DOL without the claim number will be returned. Typically it takes around 30 days from the date the patient was first seen to when the claim number is first established. The best practice is to hold onto the claim number until it is provided by the patient (contact Laverne Dolan-Dolan at 510-559-6015 if you haven't received a claim number within 30 days). Though we discourage you from doing so, you may also send the bill to the employee (who must also hold onto it until a claim number is established).

Bills must be submitted on OWCP-1500/HCFA 1500 Forms (see <http://www.dol.gov/esa/regs/compliance/owcp/forms.htm>).

Once the claim number is provided: You are free to send all medical documentation and bills directly to OWCP's Central Mail Facility:

U.S. Department of Labor
DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

It is imperative that the **claim number be written in black ink** somewhere on all invoices and paperwork. Also, because this is a P.O. box, **private carriers like UPS and Fed-Ex will not deliver.**

A copy of all subsequent work restriction/release letters must still be sent to Anastasia Williams.

Additional tips can be found here: <http://www.dol.gov/owcp/dfec/regs/compliance/CBPtools.htm>. Please feel free to contact Anastasia Williams @ (301-504-1471) if you have any additional questions.

Directions, Hours, and Contact Info for Recommended Treatment Centers

The following treatment centers are **recommended, not required**. They are recommended because they are nearby and because they have already been trained in our Agency's unique paperwork requirements. You are **STRONGLY urged** to choose a provider that is covered by your personal health insurance in the event that DOL rejects your claim.

Weekdays, 8 a.m. to 5 p.m.:

Go to the Corvallis Clinic, Occupational Medicine Department (OMD): (541) 753-1786

Weekdays, 5 p.m. to 8 p.m.: Go to the Corvallis Clinic, Immediate Care Center (ICC): (541) 754-1150

Weekends, 10 a.m. to 5 p.m.: Go to the Corvallis Clinic, Immediate Care Center (ICC): (541) 754-1150

All other hours: Go to the Emergency Room at The Good Samaritan Hospital: (541) 768-5021

The Occupational Medicine Department is located in the **Corvallis Clinic at Walnut Blvd.** at 2350 NW Century Drive (Location B on the Figure 1) and is located on the northwest corner of the Kings/Walnut intersection (opposite of the Winco Shopping Center). It can be accessed by driving north on Kings Blvd. past Winco and across Walnut Blvd. The building will be on your left.

The Immediate Care Center is located in the **Corvallis Clinic Asbury Building** at 3680 NW Samaritan Dr. and the Emergency Room is located in the **Good Samaritan Hospital**. Both these buildings (Location A on Figure 1) can be accessed by driving north on 99W or 9th Street and taking a left on NW Elks Dr. and then your first right on NW Samaritan Drive. You will pass the Emergency Room on your left first. Continue to first large parking lot **on the left** to visit the Immediate Care Center.

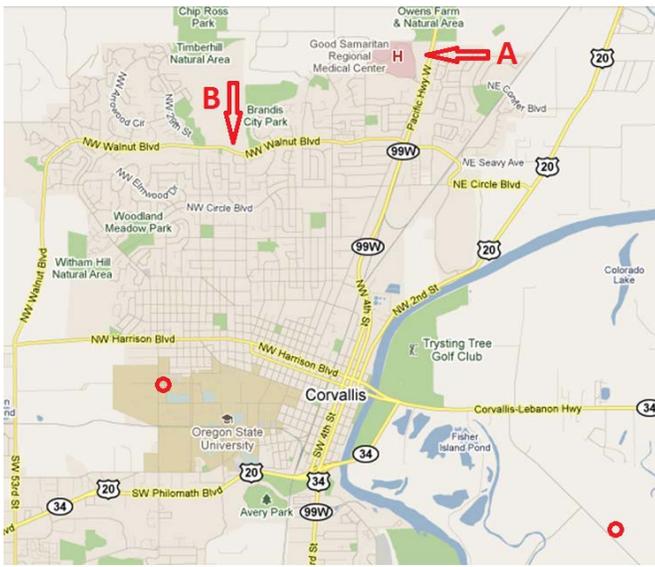


Figure 1: Directions to Treatment Centers (Research Unit Locations are Circled)

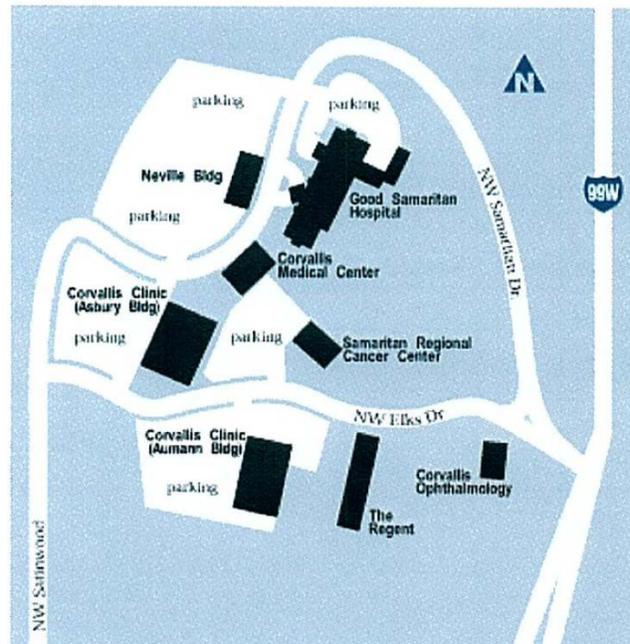


Figure 2: Expanded Map of Location A