Explanation of Form CA-1

You must click your mouse, press Enter, or use your arrow keys on your keyboard to move throughout this slide show.

Form CA-1

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

 The Form CA-1 was developed to ensure regulatory compliance and to be more customer friendly. The form must be completed by the injured employee, a witness, and the injured employee's supervisor.

Continuation of Pay/Con	and the second second	10	Office of Workers		tion rogram.		-4
Employee: Please complete a Witness: Complete bottom se Employing Agency (Superviso	ction 16.				h and c		
Employee Data	of comper	Isauon opecianacy	Complete shaded	DOXES a,	D, and C.		
I. Name of employee (Last, First, Mic	tdle)					2. Social Sec	urity Number
		BEST-GUY, Ima					
3. Date of birth Mo. Day Yi 09-27-1900		ex Male 🗌 Female	5. Home telephone		 Grade as of date of injury 	Level GS	11 Step 02
. Employee's home mailing address	(Include city, s	state, and ZIP code)				8. Dependent	ts
123 East Happy Go Lucky Blvd	J.					Wife, I	
							en under 18 yea
Northwest Wally's Parrot View,	Nebraska 0	1234				Other	
Description of Injury	C CHARTER					0.80	
Place where injury occurred (e.g. 2							
Outside of Suite 100, Sixth Flo	or Hallway, N	orthview Building,	5678 Crest Lane				
Time					Que		
10. Date injury occurred Time Mo. Day Yr.	a.m.	11. Date of this not Mo. Day Y	r.	e's occupation	on		
07-01-2005 3:3	0 🛛 p.m.	07-07-2005		Ve	eterinary Med	ical Officer	
						a. Occupation c	
Left lower arm, top part of the r Employee Signature	t the injury des	cracked/fractured, a	and bruising.	myself or a	another person	b. Type code OWCP Use - N he nor by	c. Source co
Left lower arm, top part of the r Employee Signature 15.1 certify, under penalty of law, that United States Government and th	t the injury des tat it was not ca edical treatment of (COP) not to im is denied, I emed an overpart hospital (or an partment of Lat	crited above was sus aused by my willful mir nt, if needed, and the l exceed 45 days and o understand that the cc ayment within the mea my other person, institu	nd bruising, tained in performance o sconduct, intent to injury following, as checked by compensation for wage ontinuation of my regulat postinuation of my regulat tion, corporation, or goo. Compensation Program	y myself or a elow, while loss if disab ir pay shall l vernment ag ns (or to its	enother person disabled for wo bility for work or be charged to s ency) to furnis official represe	b. Type code OWCP Use - N he nor by rk: sick h any ntative).	c. Source of
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Left lower arm, top part of the in Employee Signature 15. I certify, under penalty of law, tha United States Government and th my intoxication. I hereby claim A. Continuation of regular pa beyond 54 days. If my call A. Continuation of regular pa beyond 54 days. If my call D. Sick andfor Annual Leave I hereby authorize any physician A. De Sick andfor Annual Leave I hereby authorize any physician A program whe law for the FEGA or with of remedies as well as felony criminal Have your supervisor complete t Witness Statement 16. Statement of witnens (Decorbe w A S I was waiking towards Suite door. I ran quickly to him and, with a hornfying look of pain to I anded on his left arm first. I co Name of witness	the injury des at it was not created in the injury des at it was not created in the injury des at it was not created in the injury of the injury of the injury of the injury of the injury injury of the injury of the injury hospital (or an artificial repression and any false stated any false stat	cracked/fractured, a cribed above was sus sused by my willial min in freeded, and the is exceed 45 days and understand that the co ayment within the meat my other penson, institute or Office of Viewkers' entative of the Office Is where behalf meant, misregresentalities to some present the some present of the Office Is where behalf meand, or know about the day. July 1, 2005, at up (eitting) and aske e claimed he thougi and asked for an a	nd bruising. tained in performance o acconduct, linent to nijny acconduct, linent to nijny acconduct, linent to nijny acconduction accondu	r myself or a elow, while iloss if disat r pay shall if vernment ag ms (or to its any records or any othe intilled is su be punish our record aw Mr. Bes te cause in a because h	Inother person disabled for wo be charged to su- ency) to furnisi ency) to furnisi official represen- concerning me <u>p</u> ract of fraud to be to civil or ed by a fine or s .	b. Type code OWCP Use - N he , nor by trk: b. Type code of bank compensations administrative b. 2ate obtain compensation administrative impliatorment or d fall right outsto- ck and was ho	c. Source o OI Code ation both. ide the suite lding his arm when he
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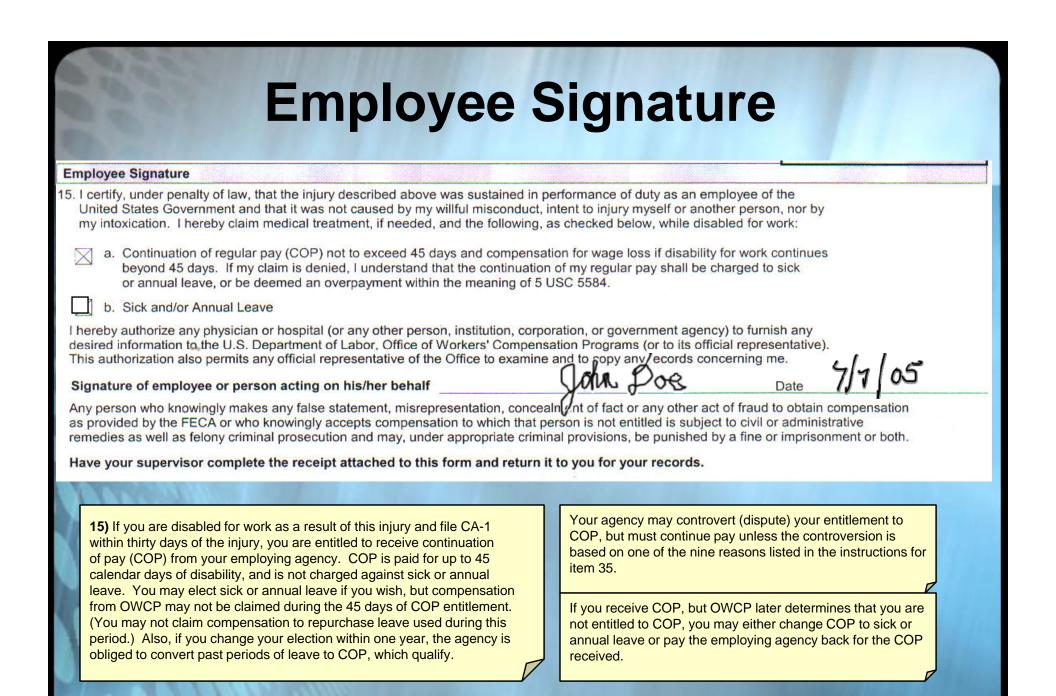
Process of Form CA-1

Form CA-1 is available at: <u>http://www.dol.gov/esa/regs/compliance/owcp/ca-1.pdf</u>

Steps to Complete Form CA-1:

- (1) The employee, who is claiming traumatic injury and claim for continuation of pay/compensation, must complete all boxes 1-15, including signature.
- (2) The witness must then complete box 16, including signature.
- (3) The supervisor must complete the Supervisor's Report, 17-38, including signature. They must also complete the Privacy Act Section on page 3.
- (4) Page 2, box 39, supervisor must check the appropriate filing instructions box.

100	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compens. Employee: Please complete all boxes Employee: Please complete all boxes	
Where there is a	Witness: Complete bottom section 16 appropriate boxes	
box to indicate	Employing Agency (Supervisor or Compensatio	
a choice, simply	Employee Data 1. Name of employee (Last, First, Middle)	2. Social Security Number
click on the	BEST-GUY, Ima	123-45-5678
appropriate box	3. Date of birth Mo. Day Yr. 4. Sex 5. Home telephone 6. Grade as of	
to make your	09-27-1900 📩 🔀 Male 🗌 Female 987-654-3210 date of injur	y Level GS11 Step 02
selection	7. Employee's home mailing address (Include city, state, and ZIP code)	8. Dependents
	123 East Happy Go Lucky Blvd.	Wife, Husband
		Children under 18 years
Describe in detail	Northwest Wally's Parrot View, Nebraska 01234	Other
ow and why the	Description of Injury	
njury occurred.	9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)	
Give appropriate	Outside of Suite 100, Sixth Floor Hallway, Northview Building, 5678 Crest Lane	
etails (e.g.: if you		
II, how far did you	10. Date injury occurred Time a.m. a.m. 11. Date of this notice 12. Employee's occupation Mo. Day Yr. No. Day Yr.	
fall and in what	Mo. Day Mo. <td>dical Officer</td>	dical Officer
position did you	13. Cause of injury (Describe what happened and why)	
land?)	As I was walking out of Suite 100 on the Sixth Floor, I slipped on the wet tile floor. I landed on my left arm	
	discovering that my left radius bone cracked from the ulna bone colliding with it when I fell. I slipped beca was no sign to warn anyone of the floor being wet.	ause the floor was wet. There
4) Give complete		a. Occupation code
lescription of the		
ndition(s) resulting	14. Nature of injury (Identify both the injury and the part of the body, e.g., fracture of left leg)	b. Type code c. Source code
rom your injury.	Left lower arm, top part of the radius bone cracked/fractured, and bruising.	
becify the right or	\wedge	OWCP Use - NOI Code
side if applicable		
.g.: fractured left	ployee Signature	
leg; cut on right index finger).	15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of t United States Government and that it was not caused by my willful misconduct, intent to injury myself or another person my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for we	i, nor by
	a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work or beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to a or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.	
A BARA	b. Sick and/or Annual Leave	contact. The list
	I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnis desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative of the Office to examine and to copy any records concerning methods.	th any entative). of contacts can
	Signature of employee or person acting on his/her behalf	
1	Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or	o obtain c
	Have your supervisor complete the receipt attached to this form and return it to you for your records.	



Witness Signature

Witness Statement

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

As I was walking towards Suite 100, on Friday, July 1, 2005, at around 3:30pm, I saw Mr. Best-Guy slip and fall right outside the suite door. I ran quickly to him and propped him up (sitting) and asked if he was okay. He was in a state of shock and was holding his arm with a horrifying look of pain on his face. He claimed he thought he broke his arm, because he heard a crack in the bone when he landed on his left arm first. I called security and asked for an ambulance to come for Mr. Best-Guy.

	Crystal E. Cheor	7	-7-65
Name of witness	G Signature of witness		Date signed
Clear, Crystal E.			
Address	City	State	ZIP code
911 Alwaystheretohelp Street	Northwest Wally's Parrot View	Nebraska	01234
This form was electronically produced by Elite Federal Forms, Inc.			Form CA-1 Rev. Jan 1997
SWIRE CONTRACTOR			
A VI B D D D D D D D D D D D D D D D D D D			
A CONTRACTOR OF A CONTRACT			

Supervisor

At the time of the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to Worker's Compensation contact within 3 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.

and the second s	Official Sumania and Baseda Bl			18) The a	ddress and	A REAL PROPERTY AND A REAL	
17) The name and	Official Supervisor's Report: Pl				do of tho		
address of the	Supervisor's Report 17. Agency name and address of i	36) COP may be cor				OWCP Agency Code	
office to which	ABC123 Inc., Suite 100, Si	th F however, the employ				OWCF Agency Code	
correspondence	V	only if the controvers	sion is based ι	pon one of	the nine	OSHA Site Code	
from OWCP should	5678 Crest Lane, Northwes		/:			710.0-1-	
	 Employee's duty station (Stree 5678 Crest Lane, Northwest 					ZIP Code 01234	
be sent (if applicable,	19. Employee's retirement coverage	a) The able ability on an	ults from an oc	cupational c	disease		
the address of the		or illness;					
personnel or		🐃 b) The employee is a	a volunteer wo	rking withou	ut pay or for		
compensation).		nominal pay, or a me	ember of the o	ffice staff of	a former	ed. 🔀 Thurs. 🔀 Fri. 📃 Sat.	
. , ,	retirement system the	President;				a.m.	
30) A third party is an	employee is covered	c) The employee is r	neither a citize	n or a reside	ent of the Unite	d Time: 8:00 p.m.	
individual or	under.	States or Canada;				🖂 a.m.	
organization (other	stopped 08-02-2005	d) The injury occurre	ed off the emp	oying agend	cy's premises	Time: 8:00 p.m.	
than the injured	28. Was employee injured in perfo					1 M M	
employee or the		duties;					
federal government)		e) The injury was ap	proximately ca	aused by the	e employee's		
who is liable for the	29. Was injury caused by employe	willful misconduct, in				Yes," explain) 🛛 No	
injury. For instance,		or another person, o	-	, ,			
the driver of a vehicle	30. Was injury caused 31.	1) The injury was not		orm CA-1 w	vithin 30 days	date of the	
causing an accident	30. Was injury caused 31. by third party?	following the injury;			· · · · · · · · · · · · · · · · · · ·	it to the	
in which an employee	🛛 Yes 🔲 No	g) Work stoppage fir	st occurred 90	days or mo	ore following the	e n listed in	
is injured, the owner	(If "No," CI go to	injury';		, , , , , , , , , , , , , , , , , , ,	0	h 32.	
of a building where	ite and and a	734 h) The employee init	tially reported	the iniurv af	ter his or her		
Ş	32. Name and address of physicial			, <u>,</u> , , , ,		date	
cause an employee	Dr. Does A. Goodjob, Ltd.	i) The employee is e		Civil Air Pati	rol, Peace	ical care Mo. Day Yr. ived 07-01-2005	
to fall, and a		Corps Youth Conse				01012000	
manufacturer whose	8700 Hospital Ct., Parrot V	Programs, or other s			, ,	nedical rts show 🔄 Yes 🖂 No	
defective product		- 3 ,	5 - 1			loyee is	
	35. Does your knowledge of the fa	ts al				Yes No (If "No," explain)	
injury, could all be							
considered third parties							
	36. If the employing agency contro	erts continution of pay, state the	nurse or oth	or boolth	37. Pa	av rate	
					wh	en employee opped work	
			profession			69,788.00 Per year	
	Signature of Supervisor and Fil		physiciar	,			
	 A supervisor who knowingly ce may also be subject to appropri 	tifies to any false statement, misi ate felony criminal prosecution.	employing		ct, etc., in respect of	of this claim	
All and and	and the second	and herein above and that furnished by th	health unit	or clinic,	form is true to the	best of my	
AAAAA	knowledge with the following ex		indicate t	his on a			
			separate				
	Sallie A. Miller		pap		J		
	Name of supervisor (Type or print)						
	Signature of supervisor			D	ate		
	Supervisor's Title	50		0	ffice phone		
	Assistant (no: Place this fam		(12	23) 456-7890	
		o lost time and no medical expen- lost time, medical expense incu					
		st time covered by leave, LWOP					
		st Aid Injury				Form OA 4	and the second second
						Form CA-1 Rev. Jan 1997	

Supervise	or's Signature
Signature of Supervisor and Filing Instructions	
38. A supervisor who knowingly certifies to any false statement, misrepre may also be subject to appropriate felony criminal prosecution.	esentation, concealment of fact, etc., in respect of this claim
I certify that the information given above and that furnished by the em knowledge with the following exception:	nployee on the reverse of this form is true to the best of my
Knowledge with the following exception.	
Sallie A. Miller	
Name of supervisor (Type or print)	
Signature of supervisor	Date 7805
Supervisor's Title Assistant CEO	Office phone (123) 456-7890
	Form CA-1 Rev. Jan 1997

-	The FECA, which is administered by the Of	Privacy A	-	
	disability extends beyond such period.(3) Payment of compensation for permane		pated that it will exceed, 45	ure
Receipt of Notice of Injury	certain organs, members, or functions	of the body (such as CA-7, with supporting medical ev	vidence, must be filed with	Receipt of Notice
Name of injured employee)	۳ .			Supervisor will give
Vhich occurred on (Mo., Day حتاب ا, 2005 t (Location)	/, ¥r.)	15149. 5678 Crest	LNDE	this receipt to the injured employee.
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	, Yr.) Fl. Northniew	15/43. 5678 Crest	LNNR	•
Vhich occurred on (Mo., Day حتاب 1, 2005 It (Location)	, Yr.) Fl. Northniew		LNTE	injured employee.
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	, Yr.) Fl. Northniew	Title	LNTE	injured employee.
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	, Yr.) Fl. Northniew ;Xtor	Title Assistant CED		injured employee. Date (Mo., Day, Yr.) 78,05 Form CA-1
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	Note: This notice applies to all forms re	Title Assistant CED		injured employee. Date (Mo., Day, Yr.) 78,05 Form CA-1
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	Note: This notice applies to all forms reprocessnig and adjudication of the claim	Title Assistant CED questing information that you might receive from the Office in connect n you filed under the FECA.		injured employee. Date (Mo., Day, Yr.) 78,05 Form CA-1
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	Note: This notice applies to all forms reprocessing and adjudication of the claim	Title Assistant CED questing information that you might receive from the Office in connect n you filed under the FECA.		injured employee. Date (Mo., Day, Yr.) 78,05 Form CA-1
Vhich occurred on (Mo., Day J. 2003 I. 2003 It (Location) Suite 100, CM ignature of Official Superior	Note: This notice applies to all forms reprocessing and adjudication of the claim Receipt of Notice of Injury This acknowledge receipt of Notice of Injur (Name of injured employee)	Title Assistant CED questing information that you might receive from the Office in connect n you filed under the FECA.		injured employee. Date (Mo., Day, Yr.) 78,05 Form CA-1

Worker's Compensation Contact List



Click on the button to view the list of Worker's Compensation Contacts

QUESTIONS?

If you have any questions on completing this form, please contact:

Denise Coleman

OWCP Program Manager

301-734-8350

or

Marquess Commodore

Worker's Compensation Specialist

301-734-8133

Safety, Health, and Employee Wellness Branch