Federal Employees’ Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Summary

Purpose

Official notice to the employee’s supervisor and to the OWCP that a traumatic injury has been sustained (or it is alleged to have been sustained).

General Procedures and Preparation Responsibilities

a. The employee, or the employee’s representative, desiring to report an injury or claim benefits under the FECA, is provided a CA-1 by his or her supervisor.

b. The employee or the representative completes items 1–15 and submits the form to his or her supervisor.

Note: When emergency medical care is required, the form may be completed after medical care has been provided.

c. The supervisor, after reviewing the employee’s portion of the form for accuracy and completeness, completes and returns the attached receipt to the employee. At this time, the supervisor should advise the employee if the claim will be controverted; if there is doubt, the employee should be advised that a decision to controvert will be made after an investigation is made.

d. The supervisor completes the supervisor’s portion of the form. The control office or point completes items 23–26.

e. The supervisor prepares Form 1769, Accident Report.

f. The supervisor submits the completed form and witness statement(s), if available, and a copy of the Form 1769, to either the control office or the control point.

Timeliness

The employee is required to submit the claim within 2 working days following the injury. Statutory time requirements are met if filed within 3 years. To be eligible for COP, the claim must be filed within 30 calendar days following the day of injury. OWCP requires that the completed CA-1 be submitted to the office within 10 working days following receipt of the claim from the employee.
Instructions

Providing the Form

When an employee desires to report a traumatic injury, and the description of how the injury took place fits an on-the-job traumatic injury, the CA-1 will be provided to the employee for his or her completion. When the employee is not physically or mentally capable of completing the form, the employee’s representative completes it. A supervisor may complete the form for the employee only if it is absolutely necessary.

When the CA-1 is issued, the supervisor should provide instructions as to what is required. Basically, the employee should be advised that Items 1–15 must be completed with detailed entries. The employee must be advised that either block a or block b of Item 15 must be selected — even if no immediate disability is indicated. The employee must also be advised of the right to elect either continuation of pay or sick or annual leave in the event that disability is realized as follows:

a. An injured employee may have the option to elect sick or annual leave for the period of disability. Pay that is attributable to the period of such leave is subject to taxes and all other usual payroll deductions. Leave is limited to the amount that has been earned. An employee who elects to take sick or annual leave during the 45-day period in which continuation of pay is available, is not entitled to buy back that leave with compensation payments he or she later receives. However, if an employee elects to use sick or annual leave during a period of disability and later decides that the use of COP is desired, COP will be paid retroactively, if requested within 1 year.

b. An injured employee may have the option to elect continuation of pay for the first 45 calendar days of disability. Such pay is subject to taxes and all other appropriate payroll deductions.

When the completed CA-1 is submitted to the supervisor by the employee, or by the employee’s representative, the supervisor must review the form for accuracy, detail, and completeness. Corrections should be made by the employee or representative, if necessary. All changes should be initialed by the employee or representative.

Note: The date in Item 11 must be the date the completed CA-1 was submitted to the supervisor or another responsible USPS management representative.

The Receipt of Notice of Injury is required to be presented to the employee or the representative at the time the form is submitted to management. Such receipt is the evidence an employee needs to prove not only that a claim was submitted in the event that the original documents are lost, but also to show the timeliness of the claim’s submission.

When the receipt is completed, it is to be completed in its entirety. At this time the employee or the representative should be advised that the receipt should be retained in a safe place to ensure that it is available in the future.
Filing and Distribution

a. If the claim is not reported to the OWCP:
   (1) File the original of CA-1 in the employee’s OMF; use a sealed envelope if no OMF is available.
   (2) Place a copy in the IC claim file notated “Original in OMF.”
   (3) Send a copy to the safety office, after deleting any sensitive medical information.

b. If the claim is reported to the OWCP:
   (1) Forward an original copy of CA-1 to the district OWCP by either a USPS injury compensation control office or the office or installation designated to correspond with the OWCP.
   (2) Send a copy to the IC claim file.
   (3) Send a copy to the safety office.

First Aid Injuries

When either the initial medical visit or one-time follow-up medical care is provided to confirm full recovery following the day of injury during the employee's regularly scheduled workhours, the claim must be reported to the OWCP. This applies to medical care provided either on or off postal premises and includes treatment by both postal medical units and contract physicians. First aid injuries will be discussed in greater detail later on in this course.

Note: If the CA-1 is complete and other materials, such as medical reports and witness statements are not available, or if a controversy package is contemplated, the CA-1 should be dispatched to the OWCP with Item 38 annotated accordingly, or with a cover letter explaining the situation.

Employee’s Portion of the Form, Items 1–15

Item 1 through 15 will be completed by either the injured employee or by his or her representative.

Exceptions: The shaded blocks, a, b, and c will be completed by either the IC Control Office or control point.

The following instructions should be followed when completing the employee’s portion of the form; Items not listed are self-explanatory.

Item Explanation

6. Insert appropriate designation, i.e., PS/10; EAS/16/8, etc.

8. If “Other” in Item 8 is checked, have employee submit related information, e.g., identity and relationship. If no dependents, enter “None.”
Check appropriate box(es). If other is checked, have employee submit related information on an attachment; e.g., identify children aged 18 through 22 who are either full-time students or who are unable to care for themselves, identify dependent parents, brothers, sister, grandparents or grandchildren. Please note that married children cannot be claimed as dependents even when residing with the parent. Also, if child support is paid for children living elsewhere due to a divorce or separation, a copy of the court order is to be attached.

9. Exact location where injury occurred. If off postal premises, identify the street address, location on property or street, etc. If on postal premises, identify the building and/or room, location, work area, column, grid, parking lot location, stairwell, etc.

10. Month, day, year and time of injury. If injury developed over a period of time during a single tour, enter the time period.

11. Date of notice is the day on which the claim form is submitted.

12. The title requested is the formal title of the employee’s position within the Postal Service. This Item will be used to identify the code to be inserted into shaded block a. Claimant’s title and either FTR, PTF, PTR, Casual, TE, EAS, PCES, or other category.

13. Description of how and why the injury was sustained. If the space is insufficient, use continuation sheet.

14. Identification of the part of the body injured and type of injury such as a bruised right heel, strained lower back, etc. It is important that the employee identify all parts of the body injured to preclude later misinterpretation.

15. The claimant must check either block a or b even if there is no expected time loss. Prior to making a selection, the claimant must be advised of the COP benefit versus taking personal leave. This selection must be an informed selection. Check for signature and understanding of penalty statement.

16. Witness names and statements are obtained by the supervisor. If only one witness, have him or her complete; if insufficient space, use an attachment. If multiple witnesses, list names in Item 16 with notation to see attachments. If no witnesses, have claimant enter such and initial.

Note: Supervisor should obtain witness statement ASAP.

Official Supervisor’s Portion of the Form, Items 17–38

Items 17 through 38 will be completed by the immediate supervisor of the injured employee or by the Injury Compensation Control Office or Control Point.

Item Explanation

17. Per instructions on the form and the USPS policy, this is the identification and address of the control office authorized to communicate with the district
OWCP. This is the office authorized to receive correspondence from the OWCP. This is not always the installation in which the injured employee is employed. See Item 18.

Note: The OSHA Site Code block is not required at this time.

18. Enter the name and full address of the installation in which the injured employee is employed. This could be an associate office, a branch, a station, a repair facility, a VMF, etc.

19. a. If claimant has fixed duty hours, enter start and end times.
   b. If claimant has variable or flexible hours, enter “Variable” following “Regular Work Hours.”

20. a. If the claimant has a fixed workday schedule, check the scheduled workdays.
   b. If claimant has a rotating (carrier), or flexible schedule or a variable workday schedule, enter either “Variable” or “Rotating” and enter “Week of Injury” then check the days worked during the week of injury.

21. Enter the date of injury. If this item does not agree with item 10, enter reason in item 34 or on an attachment.

22. This is the date that the claim form was received either by the immediate supervisor or by a management representative. This item is significant to determine eligibility for COP, e.g., was the claim form submitted within 30 days after the injury.

In the event that the supervisor submits the CA-1 to the control office or point on the day of the injury before medical reports are received to determine the duty status of the claimant, Items 23–26 should be completed by the control office.

23. This item refers to the first tour of duty or date on which the injured employee either did not report to work, or stopped work, following the day of injury, due to disability caused by the traumatic injury:
   a. Enter “Did Not Stop” if employee continued on duty.
   b. Enter “Did Not Stop” if employee missed work only to obtain medical care or therapy — no disability certified.

The time entry will be either the start time of the first tour of duty missed, following the day of injury, or the actual time the employee departed the work area or installation, following the day of injury, due to disability, not just for medical care or therapy.

24. Enter a date only if the claimant enters a leave without pay (LWOP) status following the day of injury.

25. a. If there is neither no period of certified disability for which COP is paid, nor absences from scheduled duty hours for medical care or therapy for which COP is paid, enter “NA.”
b. If disability is certified immediately following the injury, the 45-day period of COP can be either: (1) the day following the day of injury even if it is an unscheduled day or a holiday (all holidays that fall within a period of COP will be counted as a day of COP, but holiday pay will be given), or (2) if the injury was realized during an overtime preceding the scheduled tour of duty, and if certification of disability verified that the employee could not report to the next scheduled tour, then the date could be the day of injury.

c. If the CA-1 was submitted more than 30 days after the day of injury, enter “Not Eligible.”

26. If the employee did not stop work (i.e., no disability), enter “Did Not Stop Work.” Remember that this item must agree with Item 23. If disability has been realized, and the employee has not returned to duty before submission of the CA-1 to the OWCP, enter “Has Not Returned.”

27. Was the claimant on the clock, on the assigned route, involved in horseplay, etc. If the supervisor cannot make a definite judgment, enter “Undetermined.”

28. If it is possible to definitively answer this Item either Yes or No, do so. However, if there is any possibility that a Yes answer could not be supported upon investigation, enter “Undetermined.”

29–30. a. If there is clear evidence that a third party was not responsible for the injury, check “No.”

b. If there is clear evidence that a third party was responsible for the injury, check “Yes.” Identify the third party and have employee complete a Form 2562, Notice of Potential Third Party Claim. Assist the employee if necessary.

c. If it is unclear if a third party was responsible, enter “Undetermined.” A third party is an individual or organization (other than the injured employee or the federal government) who is liable for the illness or disease.

31. This Item is to be completed with information related to the first physician who first provided medical care to the injured employee.

Note: If initial care was given by a nurse or other health professional (not a physician), indicate this on a separate attachment. The attachment should include at least the name, position, date of treatment, diagnosis, and address of the health professional. Note that a physician’s assistant is not a physician under the Act. Reports from physician’s assistant may be accepted only if countersigned by a physician.

If initial treatment was provided by a health unit nurse or contract physician enter word “Agency.”

32. This is the date of the first visit to the physician listed in Item 31.
33. Refer to either a CA-17, acceptable medical reports, or other reliable sources, i.e., conversation with the treating physician, or personal knowledge relative to the seriousness of the injury.

34. a. If information is available (first hand, not hearsay) that contradicts the claimant’s information, check the No block and submit the documentation either in Item 34 or on an attachment. Indicate whether attachment is provided.

b. If a determination cannot be made pending the completion of an investigation, enter “Decision Pending Investigation.”

c. If there is no contradictory information, check the Yes block.

35. If there is clear evidence that either the total claim or COP should be controverted, state the reason of the controversion in detail in the space provided. Advise the employee of your intent to controvert and the justification of the controversion action.

36. Enter claimant’s annual or hourly base pay rate. If normal schedule includes night time differential or Sunday premium, such compensation should be included. Leave blank if Item 23 is blank or insert “Did Not Stop.”

37. Supervisors should be aware of the penalty warning contained in this Item and enter commercial telephone number.

a. Printed name and signature of the supervisor completing this form.

Note: The supervisor completing the form should be the claimant’s immediate supervisor, on the day of injury or on the day notice is given.

Enter date form was completed.

b. Title and commercial phone number of supervisor completing the form.

38. Check appropriate box. If uncertain, control office will enter.
# Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

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

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**Employee Data**  
1. Name of employee (Last, First, Middle)  
2. Social Security Number

<table>
<thead>
<tr>
<th>3. Date of birth</th>
<th>4. Sex</th>
<th>5. Home telephone</th>
<th>6. Grade as of date of injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo. Day Yr.</td>
<td>Male</td>
<td>Female</td>
<td>( )</td>
</tr>
</tbody>
</table>

7. Employee's home mailing address (include city, state, and ZIP code)

8. Dependents  
   - Wife, Husband  
   - Children under 18 years  
   - Other

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**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.  
11. Date of this notice: Mo. Day Yr.

12. Employee's occupation

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)

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**Employee Signature**  
15. I certify, under penalty of law, that the injury described above was sustained in the 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 5564.
   - 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**

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

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**Name of witness**  
**Signature of witness**  
**Date signed**

**Address**  
**City**  
**State**  
**ZIP Code**

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*Form CA-1*  
Rev. Sept. 1993
Official Supervisor's Report: Please complete information requested below:

17. Agency name and address of reporting office (Include city, state, and ZIP code)

18. Employee's duty station (Street address and ZIP code)

19. Regular work hours
   From: ________ a.m. To: ________ a.m.
   ________ p.m. To: ________ p.m.

20. Regular work schedule

21. Date of injury
    ________ Mo. ________ Day ________ Yr.

22. Date notice received
    ________ Mo. ________ Day ________ Yr.

23. Date work stopped
    ________ Mo. ________ Day ________ Yr.
    Time: ________ a.m. ________ p.m.

24. Date pay stopped
    ________ Mo. ________ Day ________ Yr.

25. 45 day period began
    ________ Mo. ________ Day ________ Yr.
    Time: ________ a.m. ________ p.m.

26. Date returned to work
    ________ Mo. ________ Day ________ Yr.
    Time: ________ a.m. ________ p.m.

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

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

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

30. Name and address of third party (Include city, state, and ZIP code)

31. Name and address of physician first providing medical care (Include city, state, ZIP code)

32. First date medical care received
    ________ Mo. ________ Day ________ Yr.

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

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

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

36. Pay rate
    when employee stopped work
    $ ________ Per

Signature of Supervisor and Filing Instructions

37. 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:

   [Signature of supervisor (Type or print)]

   [Signature of supervisor]

   [Date]

   [Supervisor's Title]

   [Office phone]

38. Filing instructions
   [Box checked]
   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

Form CA-1
Rev. Sept. 1993

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Disability 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; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)

2. Payment of compensation for wage loss after the 45 days, if disability extends beyond such 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 disfigurement of the head, face, or neck.

4. Vocational rehabilitation and related services where necessary.

5. Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

1. The employing agency receives medical information from the attending physician to the effect that disability has terminated;

2. The OWCP advises that pay should be terminated; or

3. The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, 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. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

Receipt of Notice of Injury

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

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

At (Location)

Signature of Official Superior Title Date (Mo., Day, Yr.)
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 file CA-1 within thirty days of the injury, you are 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. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.)

Also, if you change your election within one year, the agency is obliged to convert past periods of leave to COP, which qualify.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for Item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

**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 38, the supervisor is responsible for obtaining the witness statement in Item 15 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 controversation 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.

29) **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.

31) **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.

**Employing Agency - Required Codes**

Box e (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.

* U.S. GPO: 1993-362-117/99080 Form CA-1
Rev. Nov. 1989

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