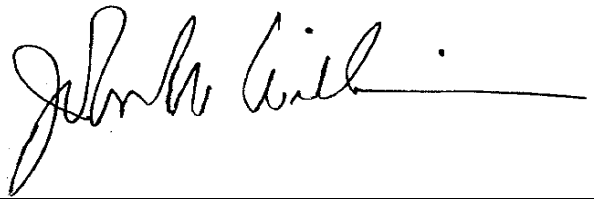
UNITED STATES DEPARTMENT OF AGRICULTURE
Farm Service Agency
Washington, DC 20250

Notice PM-2423

For: State and County Offices and Kansas City Offices

Workers Compensation Policies and Procedures

Approved by: Deputy Administrator, Management



1 Overview

A Background

On July 2, 1999, the Federal Worker 2000 Presidential Initiative was signed establishing improved timeliness of injury reporting as a major goal for Federal agencies. Over the next 5 years, agencies were expected to improve timeliness of reporting of injuries and illness by 5 percent each year. The Secretary of Labor will report to the President on the timeliness of CA-1, CA-2a, and CA-7 submission by agencies each year.

Federal agencies are required to submit CA-1, CA-2, and CA-2a within 10 working days or 14 calendar days from an employee, if lost time from work or medical expenses are claimed or anticipated according to 20 CFR 10.110(a). Regulations require that CA-7 be submitted no later than 5 workdays or 7 calendar days from the employee according to 20 CFR 10.112 (b).

B Purpose

This notice:

- advises all State and County Offices about the Office of Workers Compensation Program's (OWCP) policies and procedures

- provides instructions on completing applicable forms.

Disposal Date	Distribution
February 1, 2005	State and County Offices and Kansas City Offices; State Offices relay to County Offices

1 Overview (Continued)

C Contacts

If there are questions about this notice, contact the appropriate office according to the following chart.

IF located in…	THEN contact…
a FSA State Office	Maria T. Ruiz, at 202 418-9034 or e-mail at Maria_Ruiz@wdc.usda.gov.
a FSA County Office	State Office.
Kansas City FSA Complex, RMA Kansas City Offices, or St. Louis Office	Either of the following Kansas City, HRD employees: • Dana Candler at 816-926-6117 • Toni Sieben at 816- 823-3308.

D Labor Relation Obligations

Where exclusive representation exists, bargaining may be requested to the extent allowed by applicable statutes. Where contract language already addresses these policies and procedures for bargaining unit employees, contract language prevails.

E Calculating CA-1, CA-2, and CA-7's Timeliness

Timeliness may be calculated as follows:

- time begins when the supervisor receives notice of injury (CA-1, item 23)
- time stops when OWCP District Office receives any of the CA forms

CA-7 timeliness may be calculated as follows:

- timeliness rate is percentage of claims received within 7 calendar days or 5 work days
- time begins when CA-7 is received in HRD
- date stamp CA-7 and complete the supervisor's section immediately
- FedEx to the respective District Office within 5 work days from the stamped date.

2 Assigning Proper Codes When Processing CA Forms

A Coding the Shaded Area of CA Forms

During an analysis of OWCP data, it was determined that approximately 20 percent of CA-1's, CA-2's, and CA-2a's received by OWCP are coded incorrectly. These coding inaccuracies can be serious program deficiencies. To ensure that the coding is correct, State Offices shall:

- use the injury/illness, source/type codes in CA-810, Appendix B, that can be downloaded from the web at **www.dol.gov/esa/regs/compliance/owcp/fecacont.htm**
- limit classifying injuries/illness as "Unclassified" or "Unknown", unless necessary
- establish an internal review process to ensure that forms are not forwarded to the Department of Labor (DOL) unless properly coded.

Note: In most cases, sufficient information is available from the narrative description of the injury/illness to make an accurate classification.

B Occupational Code

The occupational code is made up of the employee's pay plan and occupational series.

Example: If the employee's pay plan is "GS" and occupational series is "0203", then the occupational code for that individual employee will be "GS-0203." DOL requires that the "Occupational code" block be completed when processing CA-1, CA-2, and CA-2a. See Exhibit 1. Since every employee does not have the same occupational code, the occupational code must be verified by either of the following:

- employee's last SF-50
- National Finance Center (NFC) data base,
- IRIS Screen 122, pay plan line.

C Injury/Illness and Source/Type Code

It is required that injury/illness and source/type code items be completed when processing CA-1, CA-2, and CA-2a. See Exhibit 1.

Note: Refer to CA-810, Appendix B for source/type codes.

2 Assigning Proper Codes When Processing CA Forms (Continued)

D Agency Chargeback Codes

DOL activated new agency's chargeback codes in 2001 to identify State and County employees. The State 2-letter abbreviation has been added behind the 4-digit agency chargeback codes representing each respective State. OSHA **requires** that the "agency chargeback code" item be completed when processing CA-1, CA-2, and CA-2a.

Example: A federal employee located in Illinois would be assigned an OWCP chargeback code of 8505-IL. See Exhibit 2.

Note: Refer to Notice PM- 2414 for chargeback codes when processing:

- CA-1
- CA-2
- CA-2a.

E OSHA Site Code

OSHA requires that the "OSHA Site" code item be completed when processing CA-1, CA-2, and CA-2a. The OSHA site code should be the organizational structure code assigned to the employee's position. The organizational structure code may be verified by using either of the following:

- employee's last SF-50
- NFC's Data base,
- IRIS Screen 122 organizational Structural line.

The OSHA site code for:

- State Office employees shall begin with the letters FA

  Example: FA-04-43-0034-00

- County Office employees shall begin with the letters CE.

  Example: CE-03-46-0087-00

Note: The code should then be carried out to the 12th digit including FA or CE.

3 Maintaining OWCP Files

A Establishing SF-66 Medical Files

When an injury is reported, SF-66 shall be established and shall include copies of the following information:

- all CA forms
- all medical documentation
- medical bills
- doctor's certificate of absenteeism
- employee's T&A's
- employee's FSA-958
- employee's SF-71
- calendar showing COP days, if applicable
- correspondence from DOL
- agency correspondence, if applicable
- important notes and other correspondence.

Note: SF-66 medical files shall be kept in a central location in the office under lock and key. The information in SF-66 files is protected by the Freedom of Information Act and it belongs to DOL. Do **not** destroy or dispose of any of the information in the file except for duplicates.

B Forwarding SF-66 Medical Files Upon Separation or Retirement

Follow the guidelines in this table to forward SF-66 upon separation or retirement.

IF the employee...	**THEN...**
retires, dies, or resigns	SF-66 medical file shall be sent to the National Personnel Records Center with the employee's official personnel folder for future reference. **Note:** Maintain a log with the the following information: • name • case number • date of injury • social security number.
transfers to another agency	• make a copy of SF-66 medical file for FSA records • forward the original SF-66 medical file to the employee's new Personnel Office.

3 Maintaining OWCP Files (Continued)

C Ordering SF-66 Folders and CA Forms

SF-66 folders and all OWCP forms can be ordered from the following:

- Consolidated Forms and Publications Distribution Center
  Beltsville Service Center
  6351 Ammendale Road
  Beltsville, MD 20705

  Note: Their web address is **www.lsc.usda.gov**

- download some CA's through DOL's web site at
  www.dol.gov/esa/regs/compliance/owcp/forms.htm

  Note: When downloading CA's, look for the following color codes and print them accordingly:

  - CA-7, pink
  - CA-20, pink
  - CA-2, yellow
  - CA-2a, blue
  - CA-17, green.

D CA-8 and CA-3

CA-8 and CA-3 are obsolete. CA-8 has been replaced with CA-20.

4 Sending Correspondence to DOL District Offices

A Where to Send CA Forms

All CA forms should be sent to your designated District Office. This information can be found at **www.dol.gov/esa/regs/compliance/owcp/infoemp.htm**

You may find your designated District Office's telephone number and address at **www.dol.gov/esa/contacts/owcp/fecacont.htm**.

4 Sending Correspondence to DOL District Offices (Continued)

B Where to Send Other Information

All other correspondence and medical bills should be sent to:

U.S. Dept. of Labor
DFEC Central Mailing Room
P. O. Box 8300
London, KY 40742-8300

Example of CA-1 for Federal Employees

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

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
Doe, John E.	000-00-0000

3. Date of birth Mo. Day Yr.	4. Sex	5. Home telephone	6. Grade as of date of injury
02/03/1971	Male	(000) 737-4050	Level 12 Step 06

7. Employee's home mailing address (Include city, state, and ZIP code)	8. Dependents
348 Fairbank Rd. Oregon, Illinois 00917	[X] Wife, Husband [X] Children under 18 years [ ] Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
OLGE County FSA Office, 213 W Pines Rd. Oregon, IL 61061

10. Date injury occurred Mo. Day Yr.	Time	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
03/19/2001	01:00 [ ] a.m [✓] p.m	03/19/2001	Personnel Management Specialist

13. Cause of injury (Describe what happened and why)

While on my way to the copy machine my right foot was caught on the carpet, twisting right ankle and causing me to fall.

14. Nature of injury (Identify both the injury and the part of body ,e.g., fracture of left leg)

As a result my right ankle was swollen with pain on right foot, ankle and leg.

a. Occupation code	
GS-1101	
b. Type code	c. Source code
210	0110
OWCP Use - NOI code	

Employee Signature

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 for another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

[✓] b. 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.

[ ] a. 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 *John E. Doe* Date 03/19/2001

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

Form CA-1
Rev. Apr. 1999

Example of CA-1 for Federal Employees (Continued)

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

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and ZIP Code)
OGLE County Farm Service Agency
P.O. Box 216

OWCP Agency Code: 8505-IL

OSHA Site Code: FA-17-82-2001-01

18. Employee's duty station (Street address and ZIP Code)
Oregon, IL 61061-0216

19. Employee's Retirement Coverage
☐ CSRS ☑ FERS ☐ Other, (Specify)

20. Regular Work Hours
From: 07:00 ☑ a.m. ☐ p.m. To: 03:30 ☐ a.m. ☑ p.m.

21. Regular Work Schedule
☐ Sun. ☑ Mon. ☑ Tues. ☑ Wed. ☑ Thurs. ☑ Fri. ☐ Sat.

22. Date of injury	23. Date notice received	24. Date stopped work	Time
Mo. Day Yr. 03/19/2001	Mo. Day Yr. 03/19/2001	Mo. Day Yr. 03/19/2001	01:30 ☐ a.m. ☑ p.m.

25. Date pay stopped	26. Date 45 day period began	27. Date returned to work	Time
Mo. Day Yr. 03/19/2001	Mo. Day Yr. 03/20/2001	Mo. Day Yr. 03/19/2001	07:00 ☑ 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 city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)
Dr. Sue Horsefeather
"The Horsefeather Clinic"
CC2C Rock Ave., Rockford, IL 61103

33. First date Medical care received
Mo. Day Yr.
03/19/2001

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.
N/A

37. Pay rate when the employee stopped word
$ 49,580.00 per Annual

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment off act, 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

Form CA-1
Rev. Apr. 1999

Example of CA-1 for Non-Federal Employees

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

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
Doe, John E.				000-00-0000
3. Date of birth Mo. Day Yr.	4. Sex	5. Home telephone	6. Grade as of date of injury	
02/03/1971	Male	(000) 737-4050	Level 12 Step 06	

7. Employee's home mailing address (Include city, state, and ZIP code)	8. Dependents
348 Fairbank Rd. Oregon, Illinois 00917	[X] Wife, Husband [X] Children under 18 years [ ] Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
Main floor, Hancock County FSA Office, 102 Buchanan, Carthage, IL 62321

10. Date injury occurred Mo. Day Yr.	Time	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
03/19/2001	01:00 [ ] a.m [✓] p.m	03/19/2001	Personnel Management Specialist

13. Cause of injury (Describe what happened and why)

While on my way to the copy machine my right foot was caught on the carpet, twisting right ankle and causing me to fall.

14. Nature of injury (Identify both the injury and the part of body ,e.g., fracture of left leg)

As a result my right ankle was swollen with pain on right foot, ankle and leg.

a. Occupation code	
CO-1101	
b. Type code	c. Source code
210	0110
OWCP Use - NOI code	

Employee Signature

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 for another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

[✓] b. 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.

[ ] a. 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 *John E. Doe* Date 03/19/2001

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

Form CA-1
Rev. Apr. 1999

Example of CA-1 for Non-Federal Employees (Continued)

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

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and ZIP Code)
Hancock County Farm Service Agency
102 Buchanan St., Carthage, IL 62321

OWCP Agency Code: 8505-IL

OSHA Site Code: CE-03-46-0087-00

18. Employee's duty station (Street address and ZIP Code)
102 Buchanan, St., Carthage, IL 62321

19. Employee's Retirement Coverage
☐ CSRS ☑ FERS ☐ Other, (Specify)

20. Regular Work Hours
From: 07:00 ☑ a.m. ☐ p.m. To: 03:30 ☐ a.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
03/19/2001	03/19/2001	03/19/2001	01:30 ☐ 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**
	03/20/2001	03/19/2001	07:00 ☑ 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 city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)
Dr. Sue Horsefeather
"The Horsefeather Clinic"
CC2C Rock Ave., Rockford, IL 61103

33. First date Medical care received Mo. Day Yr.
03/19/2001

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.
N/A

37. Pay rate when the employee stopped word
$ 49,580.00 per Annual

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment off act, 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

Form CA-1
Rev. Apr. 1999

Example of CA-2

Notice Occupational Disease and Claim for Compensation

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

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Doe, John E
2. Social Security Number: 000-01-0000
3. Date of birth: Mo. 02 Day 03 Yr. 71
4. Sex: M
5. Home telephone: (000) 737-4050
6. Grade as of date of last exposure: Level 12 Step 06
7. Employee's home mailing address (include city, state, and ZIP code):
348 Fairbanks RD
Waldorf, Illinois
8. Dependents
   - [X] Wife, Husband
   - [X] Children under 18 years
   - [ ] Other

Claim Information

9. Employee's occupation: OA Secretary
   a. Occupation code: G3-0203
10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP code): Washington, DC 20250
11. Date you first became aware of disease or illness: Mo. 06 Day 02 Yr. 03
12. Date you first realized the disease or illness was caused or aggravated by your employment: Mo. 06 Day 05 Yr. 03
13. Explain the relationship to your employment, and why you came to this realization:
On June 5, 2003 while I was using my computer to complete a project that I was working on, my arms began to hurt.
14. Nature of disease or illness: Carpal Tunnel Syndrome

OWCP Use - NOI Code
b. Type code: 620
c. Source code: 0140

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.
N/A
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
N/A
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
N/A

Employee Signature

18. *I certify, under penalty of law, that the disease or illness described above was the result of my employment with 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 other benefits provided by the Federal Employees' Compensation Act.*

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 an 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_____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

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.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

Form CA-2
Rev. Jan.1997