CA-2
NOTICE OF OCCUPATIONAL DISEASE AND
CLAIM FOR COMPENSATION

ITEMS #1 through #8 are self explanatory.

ITEM #9 asks for your occupation.
You are a City Letter Carrier!

ITEM #10 is asking for the address where you work.

ITEM #11 though not a critical date establishes the
condition (Claims must be filed within 3 years of the
injury.

ITEM #12 asks for a critical date. (You are establishing the
date of injury).
I always advise “that you see your doctor”. “Get a
diagnosis”. “Find out if the doctor feels the condition is job
related”. Then you ask for a CA-2. The date the doctor tells
you the condition is job related goes in ITEM #12.

ITEM #13 is the section used to describe what you do at
work that has “Caused or Aggravated” the claimed
injury/condition. (SHOW THE JOB DISCRIPTIONS).

ITEM #14! If you followed my advice in ITEM #12, you have
a diagnosis to put into this section.

ITEM #15 is the question where most people get the
impression a claim must be filed within 30 days of the
injury. OWCP is only asking why you did not file sooner.
The 30 days is not a requirement. (Example! I was waiting
for assistance from my union representative in filling out
the form).
ITEM #16 deals with #1) The Employees Statement. (SHOW BACK PAGE)
For this ITEM you must answer a through e. Though you will find that c does not deal with most of our injuries, it can deal with some. If the question does not deal with your condition, respond that “This question does not apply to my claimed condition”.

ITEM #17! This question asks for an explanation. “If the medical reports requested in item 2 of the attached instructions are not submitted with this form, explain the reason for the delay”.
The best response to this question that I have found! “Medical documentation will follow from my doctor of record upon receipt of an OWCP file number”. (SHOW NUMBER 2 “MEDICAL REPORT a through g, and explain information).

ITEM #18 is the signature and date section.
There is also a reminder to “Have your supervisor complete the receipt attached to this form and return it to you for your records”. You should also request a copy of the CA-2 “Supervisor’s Report” for your records.
Notice of Occupational Disease and Claim for Compensation

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.

<table>
<thead>
<tr>
<th>Employee Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of employee (Last, First, Middle)</td>
</tr>
<tr>
<td>2. Social Security Number</td>
</tr>
<tr>
<td>3. Date of birth Mo. Day Yr.</td>
</tr>
<tr>
<td>4. Sex</td>
</tr>
<tr>
<td>5. Home telephone</td>
</tr>
<tr>
<td>6. Grade as of date of last exposure Level Step</td>
</tr>
<tr>
<td>7. Employee's home mailing address (include city, state, and ZIP Code)</td>
</tr>
<tr>
<td>8. Dependents</td>
</tr>
<tr>
<td>□ Wife, Husband</td>
</tr>
<tr>
<td>□ Children under 18 years</td>
</tr>
<tr>
<td>□ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Employee's occupation</td>
</tr>
<tr>
<td>a. Occupation code</td>
</tr>
<tr>
<td>b. Type code</td>
</tr>
<tr>
<td>c. Source code</td>
</tr>
<tr>
<td>10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP Code)</td>
</tr>
<tr>
<td>11. Date you first became aware of disease or illness Mo. Day Yr.</td>
</tr>
<tr>
<td>12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr.</td>
</tr>
<tr>
<td>13. Explain the relationship to your employment, and why you came to this realization</td>
</tr>
</tbody>
</table>

| 14. Nature of disease or illness |
| OWCP Use - NOI Code |
| 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. |
| 16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay. |
| 17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay. |

<table>
<thead>
<tr>
<th>Employee Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 any official representative of the Office to examine and to copy any records concerning me.</td>
</tr>
</tbody>
</table>

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.

Official Supervisor’s Report of Occupational Disease: Please complete information requested below

19. Agency name and address of reporting office (include city, state, and ZIP Code)  
   OWS Agency Code

   OSHA Site Code

20. Employee's duty station (Street address and ZIP Code)

21. Regular work hours From: : a.m. To: : a.m.


24. First date medical care received Mo. Day Yr.

25. Do medical reports show employee is disabled for work?  [ ] Yes  [ ] No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and time employee stopped work Mo. Day Yr. Time:

28. Date and hour employee's pay stopped Mo. Day Yr. Time:

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time:

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage  [ ] CSRS  [ ] FERS  [ ] Other (Specify)

33. Was injury caused by third party?  [ ] Yes  [ ] No  
   If “No,” go to Item 35.

34. Name and address of third party (include city, state, and ZIP Code)

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to 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

The FECA, which is administered by the Office of Workers’ Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

1. Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee’s choice.
2. Payment of compensation for total or partial wage loss.
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.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee’s salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

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.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

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.

In accordance with the Privacy Act of 1974, (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 related 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 Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
[Name of injured employee]

I was first notified about this condition on [Mo., Day, Yr.]

At [Location]

Signature of Official Superior

Title

Date [Mo., Day, Yr.]

This receipt should be retained by the employee as a record that notice was filed.

Form CA-2
INSTRUCTIONS FOR COMPLETING FORM CA-2

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. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee’s behalf)

Complete items 1 through 18 and submit the form to the employee’s supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee’s statement
In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.
b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.
c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.
d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)
e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report
A statement and medical care received, along with names and addresses of physicians rendering treatment. Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filing 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 must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per day and days per week, requested above.
b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.
c) Attach a record of the employee’s absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.
d) Attach statements from each co-worker who has first-hand knowledge about the employee’s condition and its cause. (The co-workers should state how such knowledge was obtained.)
e) Review and comment on the accuracy of the employee’s statement requested above.

Item Explanations: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. 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).

23. 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.

24. First date medical care received.
The date of the first visit to the physician listed in item 23.

32. Employee’s Retirement Coverage.
Indicate which retirement system the employee is covered under.

33. Was the 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 disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupational 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, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit 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.