### Claim for Compensation

# U.S. Department of Labor

Office of Workers' Compensation Programs



b.       Leave buy back       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss of type:       Image loss; specify type, such as downgrade, loss, movement and analysis Sheet         SECTION 3 You must report any and all earnings from employment (outside your federal job); include and employment, odd jobs, involvement in insumes enterpointe, sock with as exvice with the military. Frauduelland, concealing employment of failing to report more may result in brieflance of the instructions which provide further clarification. There you worked outside your federal job for the period(s) claimed in Section 2? Refer to the instructions which provide further clarification. There you worked outside your federal job for the period(s) claimed in Section 2? Refer to the instructions which provide further clarification. There you worked outside your federal job or the period(s) claimed in Section 2? Netfer to the instructions which provide further clarification. There you worked outside your head of the section 3.         Image Name       Address       City       State       ZIP Code         Image Name       Address       Type of Work:       Section 7.       Image Name       City       State       ZIP Code	SECTION 1		E	MPLOYEE PORTION						
d. Date of Injury       e. Social Security Number         EMail Address (Optional)       Enclusive Date Range From       f. Telephone No.JFAX No.         a.       Leave buy back       intermittent?         a.       Leave buy back       Intermittent?         b.       Leave buy back       Yes         c.       Other wage loss; specify type, such as domgrade, loss specify type, such as domgrade, loss Section 4)       Intermittent?         SECTION 3 You must report any and all earnings from employment (outside you forderal byb) include any employment for which you nonverted and salary.         Sections which provide further clarification.       Intermittent, complete Form CA-7a, InterMaNaysis Sheet         SECTION 3 You must report any and all earnings from employment (outside you forderal byb) include any employment (outside nonverted and salary.         Deales enterprises, as well as service with the millary. Fraudulently concealing employment of saling to report income may result in forteliure of onemestation benefits andro criming from employment of using to report income may result in forteliure of networknew with provide further clarification.         Name       Address of Business.         Yes       Name and Address of Business.         Yes       Complete Sections 5 through 7 and a Form SF-1199A. Three Leaves Sign-up*         No       Complete Sections 5 through 7 and a Form SF-1199A. Three Leaves Sign-up*         No       Scalid Security # Complete Sections 5 through 7 a	a. Name of E	ame of Employee Last First Middle				Middle				
Month Day Year     Month Day Year     Month Day Year     SECTION 2 Compensation is claimed for:     Inclusive Date Range     From     To     Inclusive Date Range     From     To     Intermittent?     Intermittent?     Intermittent?     Go to Section 3     Go to Section 3     Go to Section 3     Go to Section 3     Section 4     Section 4     Section 5     Section 4     Section 5     Sec	b. Mailing Address ( Including City State, ZIP Code ) c. OWCP File Number									
SECTION 2       Compensation is claimed for: Inclusive Date Range From       Intermittent?       Intermittent?         a.       Leave without pay       Image: Specify type, such as downgrade, loss of Type:       Image: Type: Type:       Image: Type: Type: Image: Specify type, such as downgrade, loss of Type:       Image: Type: Image: Type: Type: Type: Image: Type: Type: Type: Type: Type: Image: Type: Type: Type: Type: Type: Type: Type: Type: T							e. Social Sec	curity Numb	er	
Comparison of source large and the sense inclusive Date Range     From     To     To     Go to Section 3     If intermittent;     Constant of the section 3     If intermittent, complete Form CA-7a,     Time Analysis Sheet     Section 4     Go to Section 3     If intermittent, complete Form CA-7a,     Time Analysis Sheet     Section 4     Time Analysis Sheet     Section 4     Time Analysis Sheet     Section 7     Section 7     Sochedule Award (Co to Section 4)     Time Analysis Sheet     Section 7     Section 7     Sochedule Award (Co to Section 4)     Time Analysis Sheet     Section 7     Section 7     Sochedule Award (Co to Section 4)     Time Analysis Sheet     Section 7     Section 7     Sochedule Award (Co to Section 4)     Time Analysis Sheet     Section 7     Section 8     Section 7     Section 7     Section 7     Section 8     Section 7     Section 8     Section 7     Section 9     Section 7     Section 9     Section 7     Section 9     Section 9     Section 7     Section 9     Section 9     Section 7     Section 9     Section 9	E-Mail Addre	ss (Optional)								
a.       Leave without pay       From       To       Intermittent?         b.       Leave buy back       Go to Section 3       Go to Section 3, and Complete Form CA-7b         c.       Other wage loss; specify type,       Type:       If intermittent, complete Form CA-7a,         inght differential, etc.       Type:       If intermittent, complete Form CA-7a,         d.       Schedule Award (Go to Section 4)       Time Analysis Sheet         SECTION 3 you must report any and all earnings from employment (outside your federal job; include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as wall as evice with the military. Frauduelluty concealing employment or faining to report informed for the forther of compensation benefits and/or criminal prosecution. Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the Instructions which provide turber clarification.         Name and Address of Business:       Yes       No         P ves       Complete Sections 5 through 7 and a Form SF-1199A, 'Direct Deposit Sign-up'         If thermittent, complete Sections 5 through 7 and a Form SF-1199A, to complete Sections 5 through 7 and a Porm SF-1199A to reflect change(s)       No - Complete Section 7.         Sectrol 4 is this the first CA-7 claim for compensation you have filed for this injury?       Yes       No - Complete Section 7.         If themmetidisabilit	<b>SECTION 2</b>	Compensation is o		Denne			f. Telephone	No./FAX N	ю.	
b.       Leave buy back       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss of Type:       Image loss; specify type, such as downgrade, loss, and Complete Form CA-7a, the such as downgrade, loss, and Complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the such as downgrade, loss, and complete Form CA-7a, the submitted for the period of the period of the period of the period of the submitted for the period of the period of the submitted for the transform and procession. Here, we wanted as alary, wage, income such as dodress of Business:         Image and Address of Business:       Image and Address of Business:       Type of Work:         Section 4       Is the the first CA-7 claim for compensation you have filed for this injury?       If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal and include you manecialm number at the top of the page(s).         Image file with you?       Image file with you?       Image file with you?       Image file with you?         Image file with yo			From	To Intermi	ttent?					
b.	a. 🗌 Leave	Leave without pay								
C Other wage loss; specify type;	b. 🗌 Leave									
such as downgrade, loss of				Yes	No		-		0,11,0	
d.       Schedule Award (Go to Section 4)       Time Analysis Sheet         SECTION 3 You must report any and all earnings from employment (outside your federal job); include any employment, od jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the Instructions which provide further clarification.         Mame       Address       City       State       ZIP Code         Section 4       Dates Worked:       Type of Work:         Section 4       Dates Worked:       Type of Work:         Section 4       Bates Worked:       Type of Work:         Section 4       Is the first CA-7 claim for compensation you have filed for this injury?         Image: Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"       If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal and include your name/claim number at the top of the page(s).         Name       Social Security #       Date of Birth       Relationship       Living with you?       Yes       No       - Complete Sections 7         Section 5       through 7 ar a new SF-1199A, "Direct Deposit Sign-up"       Is change as and b bear wells.       Living with you?       No       - Complete Section 7			of Type:							
Conclude: A service with the provide service with the service of the provide service of the provide service with the military. Fraudulently concealing employment or any end of the service with the military. Fraudulently concealing employment or alling to report income may result in forfailure of compensation benefits and/or criminal prosecution. <i>Have you worked outside your federal job for the period(s) claimed in Section 27 Refer to the instructions which provide truther clarification.</i> Name         Address         City         State         ZIP Code           One         Dates Worked:         Type of Work:           Section 4         Is this the first CA-7 claim for compensation you have filed for this injury?         Type of Work:           Section 4         Is this the first CA-7 claim for compensation you have filed for this injury?         Type of Work:           Section 4         Is this the first CA-7 claim for compensation you have filed for this injury?         Type of Work:           Section 4         Is this the first CA-7 claim for compensation you have filed for this injury?         Type of Work:           Section 5         through 7 and a Form SF-1199A, 'Direct Deposit Sign-up'         If changes to dependent status, after deposit findomation, or if a claim has been filed with the U.S. Civil Service Retirement, another federal network (section 7 through 7 or a new SF-1199A, if no, complete Section 7.           Ves - Complete Sections 5         through 7 or a new SF-1199A, tore filed changes to dependent status, and a form status for a dependent status, and a dow or on your attachment(s)?         Yes No for dependent status, and th	•						CA-7a,			
<pre>wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as evice with the military. Fraudulently concealing employment or faling to report income may result in forefuture of compensation benefits and/or criminal prosecution. Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the instructions which provide further clarification. Name and Address of Business:</pre>					,					
Boto       Section 4       Type of Work:         Section 4       Is this the first CA-7 claim for compensation you have filed for this injury?       Yes         Yes       Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"       If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A to reflect change(s)       No - Complete Section 7.         Section 5 List your dependents (including spouse). If additional space is necessary, provide same information requested below on separate page(s)       Living with you?         Name       Social Security #       Date of Birth       Relationship       Yes       No - for dependents not living with you complete items a and b below. ,         a. Are you making support payments for a dependent noted above or on your attachment(s)?       Yes       No If Yes, support payments are made to the support payments ordered by a court?       Yes       No       If Yes, attach copy of court order.         Section 6       a. Was/Will there be a claim made against a 3rd party?       Yes       No       If Yes, State       ZIP Code         b. Have you ever applied for or received payment under any Federal Retirement or Disability law?       Ne       Caim Number       Luit Address of VA Office Where Claim Filed       Nature of Disability and Monthly Payment       Imserporesentation, concealment of fact, or any other	Instructions w	which provide further	clarification.	orked outside your fede	eral job for t	he period(s) c	laimed in Sect	ion 2? Refer	to the	
Go 1       Dates Worked:       Type of Work:         SECTION 4       Is this the first CA-7 claim for compensation you have filed for this injury?         Yes       Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"         If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Vetera Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7         SECTION 5 List your dependents (including spouse). If additional space is necessary, provide same information requested below on separate page(s).         Name       Social Security #       Date of Birth       Relationship       Yes       No       For dependents not living with you?         Name       Social Security #       Date of Birth       Relationship       Yes       No       For dependents not living with you?         Name       Social Security #       Date of Birth       Relationship       Yes       No       If Yes, support payments are made to with you?         Name       Social Security #       Date of Birth       Relationship       Yes       No       If Yes, support payments are made to with you?         Name       Address       City       State       ZIP Code         b. Were support payments ordered by a court?       Yes       No       If Yes, attach copy of court order. <td></td> <td>Name</td> <td></td> <td>Address</td> <td></td> <td></td> <td>City S</td> <td>tate ZIP</td> <td>Code</td>		Name		Address			City S	tate ZIP	Code	
Yes       Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"         In the product of the pro	Go to	Dates Worked:				Type of Worl	k:			
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No       retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7.	Yes	Complete Sections 5 t	hrough 7 and a Form SF-11	99A, "Direct Deposit Sigi	n-up"					
and include your name/claim number at the top of the page(s).       Living with you?         Name       Social Security #       Date of Birth       Relationship       Yes No       For dependents not living with you complete items a and b below. ,         a. Are you making support payments for a dependent noted above or on your attachment(s)?       Yes       No       If Yes, support payments are made to         Name       Address       City       State       ZIP Code         b. Were support payments ordered by a court?       Yes       No       If Yes, attach copy of court order.         SECTION 6       a. Was/Will there be a claim made against a 3rd party?       Yes       No         b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?       No       Nature of Disability and Monthly Payment         No		retirement/disability la	w, or with Department of Ve	teran Affairs, complete S	ections 5 thr	ough 7 or a ne	w SF-1199A. If	no, complete	e Section 7.	
b. Were support payments ordered by a court? Yes No If Yes, attach copy of court order. SECTION 6 a. Was/Will there be a claim made against a 3rd party? Yes No b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs? Yes Claim Number Full Address of VA Office Where Claim Filed Nature of Disability and Monthly Payment No c. Have you applied for or received payment under any Federal Retirement or Disability law? Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (CSRS, FERS, SSA, Other) No SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. 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, by which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, b punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request	and include you Name	ur name/claim number	at the top of the page(s). Social Securi	ity # Date of Birth	Relatior	Livin nship Ye	g with you? es No D For de With yo a and	ependents r ou complete b below. ,	not living e items	
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b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?         Yes       Claim Number       Full Address of VA Office Where Claim Filed       Nature of Disability and Monthly Payment         No       C. Have you applied for or received payment under any Federal Retirement or Disability law?       Nature of Disability and Monthly Payment         Yes       Claim Number       Date Annuity Began       Amount of Monthly Payment       Retirement System (CSRS, FERS, SSA, Other)         No       Date Annuity Began       Amount of Monthly Payment       Retirement System (CSRS, FERS, SSA, Other)         No       Date Annuity Began       Amount of Monthly Payment       SSA       Other         SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. 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 which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, bounished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request							py or court or	JEI.		
Yes       Claim Number       Full Address of VA Office Where Claim Filed       Nature of Disability and Monthly Payment         No       No       Claim Number       Payment under any Federal Retirement or Disability law?         Yes       Claim Number       Date Annuity Began       Amount of Monthly Payment       Retirement System (CSRS, FERS, SSA, Other)         No       Date Annuity Began       Amount of Monthly Payment       Retirement System (CSRS, FERS, SSA, Other)         No       CSRS       FERS       SSA       Other         SECTION 7       I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. 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 which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, b bounished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request			0							
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c. Have you applied for or received payment under any Federal Retirement or Disability law?         Yes       Claim Number       Date Annuity Began       Amount of Monthly Payment       Retirement System (CSRS, FERS, SSA, Other)         No       CSRS       FERS       SSA       Other         SECTION 7       I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. 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 which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, bounished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request							,	, , ,		
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Employee's Signature Date (Mo., day, year)	that the informa misrepresentati which that pers punished by a f FECA benefits. verification of e	ation provided above is ion, concealment of fa on is not entitled is su ine or imprisonment, o I understand that by s mployment/earnings fi	s true and accurate to the be ct, or any other act of fraud, bject to civil or administrative or both. In addition, a state o signing this form, if evidence	est of my knowledge and to obtain compensation a e remedies as well as cri or federal criminal convict is received suggesting p	belief. Any p as provided l minal prosec ion for FECA ossible emp	berson who kno by the FECA, c sution and may A fraud will resu loyment or ear	wingly makes a or who knowingly , under appropri ult in termination nings, I authoriz	ny false state y accepts cor ate criminal µ of all current	ement, mpensation to provisions, be t and future	

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services.

Employing Agency Portion For first CA-7 claim sent, complete sections 8 through 15. For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Sho	ow Pay Rate as of	Additional F			Ado	ditional F	Pay
Date of Injury:	Base Pay	Туре	Туре		Тур	)e	
Date:	\$ per		_				
Grade: step:		\$ per	\$ pe	er	\$	ре	r
Date Employee Stopped Wo	ork:	Туре	Туре		Тур	е	
Date:	\$ per	\$	\$pe		\$	per	
Grade: step:			<sup>v</sup> pv		Ψ	– <sup>–</sup>	
Additional pay types include, (SUB), Quarter (QTR), etc. (		nt Differential (ND)	Sunday Premium (SP),	Holiday Pr	remium (I	HP), Sut	osistence
SECTION 9 a. Does employee work a fix	xed 40-hour per week sche	dule? 🗌 Yes	No				
1. If Yes, circle scheduled			W DT DF	□s			
	nours for the two week pay				k stoppe	d.	
	XAMPLE ONLY			.,			
	S M T W TH	FS		S	МТ	W TI	H F
WEEK 1			-				
From <u>5/14</u> to <u>5/20</u>	$\begin{vmatrix} 8 & 4 & 6 & 6 \end{vmatrix}$	From	То				
WEEK From <u>5/21</u> to <u>5/27</u>	8 6 6	4 From	To	—			
b. Did employee work in posi	ition for 11 months prior to	injury?	es 🗌 No				
If No, would position have af			iniurv?	No			
SECTION 10 On date pay st							
a. Health Benefits under the FEHBP?	No Yes Code		Life Insurance?	o 🗌 Yes	Class	(D-Z c	onlv)
		d. A Retire	ment System? 🗌 No	Yes F			
b. Basic Life Insurance?	No Yes				Specify C		ERS, Otl
SECTION 11 Continuation of	Pay (COP) Received ( Sh	ow inclusive dates	-	Yes - Com Analysis S			а
From	To			No	,		
SECTION 12 Show pay statu	us and inclusive dates for p	eriod(s) claimed:	Intermittent?				
Sick Leave From	То				mittent, c		
Annual Leave From	То		Yes □No	CA-7a,	, Time Ar	nalysis S	heet.
Leave without Pay From	То		Yes □_ No	16.1			
Work From	To		Yes □_ No		e buy bac eted Form		
		es 🗌 No		oompic		10/(10.	
If returned, did employee retu	urn to the pre-date-of-iniury	iob. with the sam	e number of hours and th	ne same du	uties?		
	explain:						
SECTION 14 Remarks:							
		diffice to over follow at	4				
SECTION 15 An employing age this claim (or impedes the filing o				or conceam	nent of lac	a with res	pectio
I certify that the information giver				ny knowledg	je, with an	y excepti	ons noted
in Section 14, Remarks, above.							
Signature		Т	itle		Date	/	/
	(Agency Official)				=		
Name of Agency							
Date Claim Form Received fro	om Employee / /						
f OWCP needs specific pay i	nformation, the person who	should be contac	ed is:				
Name			itle				
elephone No.	Fax No.		E-Mail Address	 S			
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## **INSTRUCTIONS FOR COMPLETING FORM CA-7**

If additional space is needed to respond to questions on this form, attach a separate sheet of paper and write, "see attachment" in the applicable portion of the form. Please ensure the claimant's full name and claim number appear on the separate sheet(s).

If the employee does not quality for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.102, 20 C.F.R.10.103, and 20 C.F.R.10.404.

#### Notice

#### Requests for Accommodations or Auxiliary Aids and Services

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

**EMPLOYEE** (or person acting on the employee's behalf) - Complete sections 1 through 7 as directed and submit the form to the employee's supervisor. **SUPERVISOR** (or appropriate official in the employing agency) - Complete sections 8 through 15 as directed and promptly forward the form to the OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation						
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.						
3. Employment	An employee who either claims or is receiving compensation for partial or total disability must advise OWCP immediately of any return to work. An employee must report <b>all</b> outside employment, including any concurrent dissimilar employment held at the time of injury. The employee must report even those earnings which do not seem likely to affect benefits; failure to report earnings may result in forfeiture of <b>all</b> benefits paid during the period for which compensation is claimed. For example, include sales, farming, and operating (or keeping books for) a business including a family business. Report providing services (such as carpentry, mechanical work, child care, odd jobs) provided in exchange for money, goods, or other services. Report part-time or intermittent activities and any volunteer work for which any form of monetary or in-kind compensation was received. Passive investment in any public traded business is not a required reporting item.						
4. Direct Deposit Information	The Department of the Treasury requires all Federal payments be made by electronic funds transfer (EFT), also called Direct Deposit. If you have not previously signed up to receive compensation with EFT, or desire to change your current account information, please submit SF-1199A, Direct Deposit Sign Up. If you do not have a bank account, you may be required to receive your payment through Direct Express Debit MasterCard. To request information on the Direct Express Debit MasterCard, go to www.usdirectexpress. com or call 1-800-333-1795. If directed to enroll in the Program, you may contact the Department of the Treasury at 1-888-224-2950 to address any questions or concerns you may have, as well as apply for a waiver from the process. NOTE: payments to residents of foreign countries are exempt from the Treasury requirements.						
5. List your dependents	Your spouse is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability.						
6a. Was/will there be a claim made against 3rd 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 who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.						
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.						
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.						
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.						

The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C.552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

#### **Public Burden Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 13 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary (5 U.S.C. 8101 et seq.) to obtain or retain a benefit. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3229, 200 Constitution Avenue, N.W.,Washington, D.C. 20210, and reference the OMB Control Number 1240-0046. Note: Do not submit the completed claim form to this address.

#### **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 healthcare 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, to verify earnings without further written authorization, 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.