U.S. Department of Labor Employment Standards Administration

Office of Workers' Compensation Programs



a. Name of Employee Last First Middle DMB No. 1215-0103 b. Mailling Address (Including City State, ZIP Code) C. OWCP File Number d. Date of Injury Month Day Year d. Date of Injury Month Day Year J. Telephone No./FAX No. From Indusive Date Range Intermittent, complete Section 3 Intermittent, complete Form CA-7b. C. Other wage loss, specify type, and have you worked outside your federal job during the period(s) claimed in Section 3, and Complete Form CA-7b. C. Intermittent, complete Form CA-7a, Intermittent, complete Form CA-7b, Intermittent, complete Form CA-7a, Intermitten	SECTION 1		E	MPLOYEE PO	ORTION				
b. Malling Address (Including City State, ZIP Code) C. OWCP File Number	a. Name of Empl	oyee Las	st .	First		Middle	_		
d. Date of Injury SeCTION 2 Compensation is claimed for: Inclusive Date Range From Intermittent? Intermittent.	b Mailing Address	oo Unaluding Cit	v Stata ZID Cada)						
E-Mail Address (Optional) SECTION 2 Compensation is claimed for From Lave Bale Range From Lave Without pay	b. Mailing Addres	ss (including Cit	y State, ZIP Code)				C. OVVCI	i ile indili	bei
E-Mail Address (Optional) SECTION 2 Compensation is claimed for: Findusive Date Range Findusive Date Range Findusive Date Range Findusive Date Range							e. Social	Security N	Number
SECTION 2 Compensation is claimed for:	E-Mail Address (Optional)			Month	Day Year	1 , , ,	1 1	
Leave without pay Intermittent? C C C C C C C C C		·	laimed for:				f. Teleph	<u> </u>	AX No.
a. Leave without pay	OLOTION 2	impensation is c	Inclusive D	ate Range	Intormittant?		(') -	
b. Leave buy back			110111	10		0- (- 0)	[()	
C. Other wage loss: specify type. Such as downgrade, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days adwarded, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days adwarded, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days adwarded, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days adwarded, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days adwarded, loss of injoht differential, etc. If intermittent, complete Form CA-7a, days of intermittent, complete Form CA-7a, days of intermittent intermitten								omnlete F	Form CA-7h
such as downgrade, loss of night differential, etc. d Schedule Award (Go to Section 4) SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.) Yes Name and Address of Business: Name Address City State ZIP Code		•	type, ————————————————————————————————————					ompiete i	OIIII OA-16
d. Schedule Award (<i>Go to Section 4</i>) SECTION 3: Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.) Yes	such as d	owngrade, loss	of _		If intermittent, o	complete Form	CA-7a.		
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Yes			<u> </u>	during the peri	iod(s) claimed in	Section 2?			
Name	(In	clude salaried,	self-employed, commiss						
Dates Worked: Type of Work:	Yes N	ame and Addres	ss of Business:						
Dates Worked: Type of Work:		ame		Address			City	State	ZIP Code
SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury? Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up" Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retitement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim? Yes - 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): Name Social Security # Date of Birth I living with you? Social Security # Date of Birth I Relationship 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 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 No Later Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (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 or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.	Go to	-4 10/11-			_	F 1 \ \ /	•		
Yes Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"			7 claim for compananti	on vou hovo fil		<u> </u>			
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SECTION 5 List your dependents (including spouse): 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 shown above? 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? 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) 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 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. In addition, a felony conviction will result in termination of all current and future FECA benefits.	file	ed with U.S. Civ	il Service Retirement, ar	nother federal	retirement or dis	ability law, or w	vith the Dep	artment of	f Veterans
Name Social Security # Date of Birth Relationship Yes No		•	-	or a new SF-1	199A to reflect of	change(s)	☐ No -	Complete	e Section 7
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Name b. Were support payments ordered by a court? Yes								ems a and	l b below.
Name b. Were support payments ordered by a court? Yes	a. Are you making	g support paym	ents for a dependent sho	own above?	☐Yes ☐	No If Yes,	support pa	yments ar	e made to:
b. Were support payments ordered by a court?									
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Employee's Signature Date (Mo_day_vear)	compensation as administrative rer	provided by the medies as well a	e FECA, or who knowing as felony criminal prosec	ly accepts con cution and ma	npensation to why, under approp	nich that persor riate criminal pr	n is not entit rovisions, be	led is sub e punished	ject to civil or
	Employee's Signa	ature				Date (Mo dav	v. vear)		

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 Show Pay Rate as of	Additional Pay	1			Additional Pay				
Date of Injury: Base Pay	Туре	Туре			Туре				
Date: /	. \$ per	_	_ per		\$		per_		
Grade: Step:									
Date Employee Stopped Work:	Туре	Type			T	уре			
Date:/\$per					\$				
Grade: Step:	· •	_	- ' -		·		•		
Additional pay types include, but are not limited to: Nig	ht Differential (ND), Sund	day Premium	(SP), Ho	liday Pre	emium	(HP)	, Suk	osist	en
SUB), Quarter (QTR), etc. (List each separately)	, ,	•		•		. ,			
SECTION 9		_							
a. Does employee work a fixed 40-hour per week sch	edule? Yes 🔲 No 🗀								
-	M T W TH		S						
2. If No, show scheduled hours for the two week pay	/ period in which work sto	pped. Circle	the day t	hat work	stopp	oed.			
FOR EXAMPLE ONLY			_						
S M T W TH	F S WEEK 1		5	S M	<u> </u>	W T	H	F	S
WEEK 1 8 4 6 6	N 1 11	4-							
3/14 10 3/20		to	—		_				_
WEEK From 5/21 to 5/27 8 6 6	4	to							
		_							—
. Did employee work in position for 11 months prior to	injury?	∐ No							
No, would position have afforded employment for 11	months but for the injury'	? \ \ \ \ \ \	es \square	No					
ECTION 10 On date pay stopped, was employee en	nrolled in:	_		_					
		_							
. Health Benefits under	c. Optional Use Ir	nsurance? L	⊥ No L	Yes (Class_				
the FEHBP?		_		_		(1	D-Z	only))
. Health Benefits under the FEHBP? No Yes Code . Basic Life Insurance? No Yes	d. A Retirement S	_	□ No □ □ No □	Yes F		(1		• •	
the FEHBP? No Yes Code No Yes	d. A Retirement S	_	□ No □	Yes F	Plan pecify	CSR	S, Fl	• •	
the FEHBP? No Yes Code	d. A Retirement S	_	No _	Yes F (S	Plan pecify	<i>CSR</i> Time	S, Fl	ERS	
the FEHBP? No Yes Code Basic Life Insurance? No Yes BECTION 11 Continuation of Pay (COP) Received (Size) Trom / / To / /	d. A Retirement S Show inclusive dates):	System? [No _	Yes F (S S — Con alysis Sh	Plan pecify	<i>CSR</i> Time	S, Fl	ERS	
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the FEHBP? No Yes Code Basic Life Insurance? No Yes FECTION 11 Continuation of Pay (COP) Received (Section 12 Show pay status and inclusive dates for Sick Leave From/	d. A Retirement S Show inclusive dates): I r period(s) claimed:	System? [ntermittent?	No Yes	Yes F (S S — Con alysis Sh If interm CA-7a,	Plan pecify nplete neet, F	Time Form C	CA-7	ERS	;, C
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INSTRUCTIONS FOR COMPLETING FORM CA-7

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.10.106.

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 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.				
5. List your dependents	Your wife or husband 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-lime 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. It 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.				

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.