OWCP Form CA-2a Instructions

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation

Summary

Purpose

When an employee sustaining an occupational injury or disease suffers disability for work due to the original injury, and such disability occurs after the employee returned to work following the injury, and the disability is the result of (1) a spontaneous return of the symptoms of the previous injury or disease without intervening cause, or (2) the need for medical treatment, other than a usual office call, for residuals of the previous condition. In these instances Form CA-2a is required. If a new incident or injury occurs which precipitates the disability, even if the injury is to the same part of the body previously injured, or is new exposure to the same causes(s) of a previously suffered occupational disease, this constitutes a new injury and Form CA-1 or CA-2 should be filed accordingly.

General Procedures and Preparation Responsibilities

a. When an employee desires to report or claim a recurrence, a Form CA-2a will be provided to him or her, with the instruction sheet.

b. The supervisor or HRS will discuss the circumstances of the situation and consider the definition of a recurrence on the instruction sheet with the employee to determine if either a recurrence or a new injury or illness exists. If a new injury (traumatic or occupational) was realized, either a CA-1 or CA-2 should be initiated.

c. When a recurrence is identified, the *employee* should read the *Instructions for Employee* on the opposite page and complete Items 1–23 on the form.

d. Upon receipt of the completed employee's portion of the form, along with any attachments or statements, the supervisor or control office or point will complete Items 24–44.

Filing and Distribution

The Injury Compensation Office does the following:

a. Forwards the original of the CA-2a, and any attachments, medical reports, etc., to the OWCP upon completion.

b. Places a copy in the IC claim file.

c. Sends a copy to Safety if there is lost time or workday.

Instructions

Part A, Items 1–23, is completed by the employee or his or her representative.

1. Claimant's complete name: last name, first name, and middle name; enter NMN if no middle name.
2. SSN consists of *nine* digits.
3. The OWCP file number from the original traumatic (CA-1) or occupational (CA-2) claim. Verify that the date in Item 11, below, agrees with the original claim date.
4. Date of birth, *not* today's date.
5. Self-explanatory
6. Claimant's home telephone number with area code; if none, enter "None."
7. Claimant's complete home address to include ZIP+4.
8. Check appropriate box(es). If *other* is checked, have employee submit related information on an attachment. e.g., identify children aged 18 through 22 who are either full-time students or who are unable to care for themselves, identify dependent parents, brothers, sister, grandparents or grandchildren. Please note that married children cannot be claimed as dependents even when residing with the parent. Also, if child support is paid for children living elsewhere due to a divorce or separation, a copy of the court order is to be attached.
9. Address of employing establishment at time of *original* injury or disease. Entry should agree with either Item 18 of the original CA-1, or Item 20 of the original CA-2.
10. Complete address of employing establishment at the time of the recurrence, if different from Item 9.
11. Date and time of original injury or disease; refer to either Item 10 on the CA-1, or Item 29 on the CA-2.
12. Month, day, year, and time the employee first realized he or she had sustained a recurrence, i.e., when symptoms first became apparent, when new medical care required, etc.
13. Month, day, year, and time the employee stopped work because of the recurrence.

    If he or she did not lose time, enter "Did Not Stop." If employee is absent from work only to obtain medical care or therapy, this is not considered stopping work; however, the claim must be submitted to the OWCP.
14. Month, day, year, and time the employee entered a non-pay LWOP status after stopping work. If the employee does not stop work or remains in a paid leave status; sick, annual, or COP; enter "NA."
15. This Item should complement Item 13.

a. If claimant did not stop work, enter “NA.” Item entry should agree with Item 13.

b. If claimant lost time from work and has returned, enter the date and the time the employee returned to work.

c. If claimant lost time from work and has not returned to work, enter “Has Not Returned.”

16. If claimant has obtained medical care for the recurrence prior to completing the form, all dates of treatments and therapy should be listed. Use an attachment if necessary.

17. If employee has obtained medical care following the recurrence, list the source(s) of such care. If CA-16 was issued, identify physician listed in Item 1 of the CA-16.

18. This Item refers to the original injury or disease.

    a. Following the original injury or disease, if the claimant either continued or returned to his or her original duties without disability limitations, check “Not.”

    b. Following the original injury or disease, if the claimant was permanently or temporarily unable to return to his or her normal duties, check “Yes.” Describe the medically prescribed disability or limitations and describe the physical requirements of the limited or rehab duties assigned.

19. The employee is to provide a detailed description of his or her condition since returning to work following the *original* injury and a description of *all* medical care received following his or her return to work following the original injury.

20. Instructions for this Item are clear; be sure the employee provides necessary and detailed information. Be sure the information provided supports a recurrence and does not support the need for a new claim, e.g., a CA-1 or a CA-2.

21. The employee is *required* to describe *all* injuries and illnesses suffered between the date he or she returned to work following the original injury and the date of the recurrence; and, submit all medical records relevant to the injuries.

22. Self-explanatory.

23. Date the CA-2a was submitted by the employee.

Part B, Items 24–44, will be completed by the supervisor or the Human Resources Specialist.

24. This is the identification and address for the injury compensation control office or point authorized to communicate with the district OWCP. *This is not always the installation in which the employee is employed*. See item 25.

25. Enter the name and full address of the installation in which the employee is *currently* employed. This could be an AO, a branch, a station, a repair facility, a VMF, etc. Entry should agree with Item 10.

26. Enter the date the employee was returned to his or her *regular* duties following the *original* injury or illness.

27. a. If claimant has fixed duty hours, enter start and end times.

    b. If claimant has variable or flexible hours, enter "variable, DOI hours listed," and then enter scheduled work hours on day of injury (DOI).

28. a. If the claimant has a fixed workday schedule, check the scheduled days.

    b. If claimant has either a rotating (carrier) or a flexible schedule, or a variable workday schedule, enter either *rotating* or *variable* and enter *week of injury,* then check the days scheduled for the week of injury.

29. Date of original injury or illness; refer to either Item 10 of the original CA-1, or Item 29 of the original CA-2. Compare to Item 11 entry by the claimant.

30. Date of recurrence, compare to Item 12.

31. Date stopped work following the recurrence, compare to Item 13.

32. Date employee entered a non-pay LWOP status following the recurrence, compare to Item 14.

33. If disabled following the recurrence and COP was paid, enter the period of such.

    If claim is being submitted before the employee returns to duty, enter "Has Not Returned."

34. a. Date the employee returned to work following the recurrence, compare to Item 15.

    b. If employee did not stop work, enter "Did Not Stop," compare to Items 14 and 31.

35. If employee used *personal* leave during period of disability — Items 31 and 34 — list dates by type of leave used.

36. a. Enter annual/weekly/hourly base pay (includes COLA if career employee).

       Control office or point will compute, as applicable, regularly scheduled night differential and Sunday premium pay and enter in Item 36d. If employee is entitled to territorial COLA, enter dollar amount per annum/week/hourly in block 36c and identify.

    b. If pay rate changed between the date of recurrence and the date of the work stoppage following the recurrence, enter the new pay data.

    Note: When an employee works less than his or her full tour between 6:00 p.m. and 6:00 a.m., provide pay information at either the weekly or annual rate to show the *total* night differential earned for the period.

37. When an employee is provided treatment by either the PMO or a USPS contract doctor, copies of all medical data is to be provided to the OWCP.
38. Self-explanatory.
39. When either a limited duty or a rehabilitation assignment was provided following the *original* injury or illness, enclose a copy of the limited duty/rehabilitation job offer/assignment.
40. When information available to management differs from the information provided by the employee, identify and support such differences.

41– 44. Self-explanatory.

Part C of the form is completed by the claimant if he or she is no longer employed by either the USPS or another federal agency at the time of the recurrence.

In such a situation, the claimant sends the form directly to OWCP. In this situation, the former employer may not be aware of the claim unless is it accepted by the OWCP and new payments appear on the chargeback report. If or when such charges to the USPS do appear, the injury compensation personnel should acquire from OWCP current medicals to ascertain if rehabilitation is in order.

Federal Employee's Notice of Recurrence of Disability and Claim for Continuation Pay/Compensation

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

OMB No. 1215-0167
Expires: 07-31-96

Employee: Please complete Part A below.

Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

Employee Data Part A - Employee

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. OWCP file number for original injury (if known)
4. Date of birth Mo. Day Yr. ___ ___ ___
5. Sex ☐ Male ☐ Female
6. Home telephone ( )
7. Employee's home mailing address (include city, state, and zip code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other
9. Name and Address of Employing Establishment at time of original injury (number, street, city, state, zip code)
10. Name and Address of Employing Establishment at time of recurrence, if other than 9. If you are no longer employed with the Federal Government, complete Part C in addition to Part A.
11. Date and Hour of original injury (mo., day, year) ☐ a.m. ☐ p.m.
12. Date and Hour of recurrence (mo., day, year) ☐ a.m. ☐ p.m.
13. Date and Hour stopped work following recurrence (mo., day, year) ☐ a.m. ☐ p.m.
14. Date and Hour pay stopped following recurrence (mo., day, year) ☐ a.m. ☐ p.m.
15. Date and Hour returned to work (mo., day, year) ☐ a.m. ☐ p.m.
16. Dates of medical treatment following recurrence (mo., day, year)
17. Name and Address of physician treating employee following recurrence
18. After returning to work following the original injury, were you handicapped or in any way limited in performing your usual duties? (If yes, explain) ☐ Yes ☐ No
19. Describe fully your condition since you returned to work including all medical treatment received.
20. Describe the circumstances of the recurrence of disability. Explain why you believe your present condition is related to the original injury.
21. Describe all injuries and illnesses which you suffered between the date you returned to work following the original injury, and the date of recurrence. Arrange for the submission of all relevant medical 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 punishe by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay and/or Compensation while disabled for work.

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.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

22. Signature of employee
23. Date (mo., day, year)

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Part B - Employer

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

24. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

Zip Code | OSHA Site Code

25. Employee's duty station (Street address and zip code) | 26. Date of first return to REGULAR duty following original injury. Mo. Day Yr.

Zip Code

27. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

28. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

29. Date of Injury Mo. Day Yr.

30. Date of recurrence Mo. Day Yr.

31. Date stopped work following recurrence Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

32. Date pay stopped following recurrence Mo. Day Yr.

33. Date COP paid for recurrence From Mo. Day Yr. To

34. Date returned to work following recurrence Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

35. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave | b. Sick Leave | c. Other (Specify)

36. Pay Rate in Effect On:	a. Base pay	b. Subsistence	c. Quarters	d. Other Pay, i.e., Sunday premium or night differential
A. Date of Recurrence	$ per	$ per	$ per	$ per
B. Date Stopped Work following Recurrence	$ per	$ per	$ per	$ per

37. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☐ No

38. At time of recurrence did official superior authorize medical treatment on form CA-16? ☐ Yes ☐ No

39. Following the original injury, did the employer make any accomodations or adjustments in the employee's regular duties due to injury related limitation? If yes, provide full details. ☐ Yes ☐ No

40. Please review the statements provided by the employee in response to Part A of this form and provide all relevant comments and additional information.

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.

41. Signature of official superior (at time of recurrence)	42. Title	43. Official superior's work phone number	44. Date (mo., day, year)

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Part C - Employee
(To be completed by the employee if not employed with the Federal Government at the time of a claimed recurrence of disability attributed to an occupational injury or illness sustained with Federally employed.)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of all employers, and the inclusive dates of all employment. Include any self-employment.

2. For all jobs listed in number 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay when you stopped work due to this recurrence of disability?

   $ _____ per _____

5. Do you claim compensation for lost wages? ☐ Yes ☐ No

   If yes, for what period _____ through _____ .

6. Have you received any pay during the period claimed? ☐ Yes ☐ No

   If yes, how much and from what source? _____

Section 8101, et seq., Title 5 to the U.S. Code authorizes collection of this information. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Claimant Signature	8. Date

☆U.S. GPO:1993-301-192/93030

INSTRUCTIONS FOR COMPLETING FORM CA-2a
RECURRENCE OF DISABILITY

DEFINITION OF RECURRENCE

Recurrence - when an employee who sustained an occupational injury or disease suffers disability for work due to the original injury, and such disability occurs after the employee returned to work following the injury, and the disability is the result of (1) a spontaneous return of the symptoms of the previous injury or disease without intervening cause, or (2) the need for medical treatment, other than a usual office call, for residuals of the previous condition. In these instances Form CA-2a is required. If a new incident or injury occurs which precipitates the disability, even if the injury is to the same part of the body previously injured, or is new exposure to the same cause(s) of a previously suffered occupational disease, this constitutes a new injury and Form CA-1 or CA-2 should be filed accordingly.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of recurrence provided above. If you have suffered a recurrence, you should complete Part A completely. Attach a separate sheet of paper where necessary to provide full details.
- If you are employed by the Federal Government at the time of recurrence, Form CA-2a should be submitted promptly to your employing agency. If you are no longer employed with the Federal Government, you should complete Parts A and C and submit all materials directly to OWCP.
- If the original injury was not previously reported to OWCP, a report specifically covering the original injury should be made on Form CA-1 (traumatic injury) or CA-2 (occupational disease) and attached when Form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.
- If this is a recurrence of an occupational disease, or if the 45 days Continuation of Pay (COP) have been exhausted, you may claim wage loss on Form CA-7 if this form was not submitted following original injury. If Form CA-7 was previously submitted, compensation may be claimed on Form CA-8. The OWCP will be responsible for payment of compensation if the claim is approved.
- You should arrange for the submission of a detailed medical report from your attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion, with medical reasons, regarding causal relationship between your condition and the original injury. The physician should also describe your ability to perform your regular duties. If you are disabled for your regular work, (s)he should identify the dates of disability and provide work tolerance limitations.
- If you were treated by other physicians after returning to work following the original injury, similar medical reports should be obtained from each.

INSTRUCTIONS FOR THE EMPLOYING AGENCY

- Upon receipt of a claim for recurrence, the employing agency should promptly complete Part B and submit it to OWCP.
- Where pay is continued, the employing agency should obtain medical evidence on Form CA-17, "Duty Status Report", as often as circumstances indicate.
- If the recurrent disability has not ended at the time Form CA-2a is submitted, Form CA-3, Report of Termination of Disability and/or Payment, should be forwarded when the employee returns to work.
- If the recurrence happens less than six months following employee's return to work following the injury, the supervisor shall authorize required medical care by use of Form CA-16. If the recurrence happens more than six months after the employee's return to work, authorization for further medical care must be obtained from the OWCP.
- If the recurrent disability continues after the expiration of the 45 days Continuation of Pay (COP) or if this is a recurrence of an occupational disease, you should instruct the employee to file Form CA-7. If Form CA-7 was previously submitted, compensation should be claimed on Form CA-8.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including 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 the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, DC 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0167), Washington, DC 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES