



ROICC EMPLOYEE MISHAP REPORTING STEPS

If you or a coworker from your office is injured in any way please follow these steps:

- 1) Get the immediate medical attention you need. This begins by knowing the emergency service phone numbers at your location for helping you or a coworker. If your mishap is non-emergency in nature it is highly desirable that you utilize the station dispensary for assistance. A universal dispensary form for the employee to use is attached below (Attachment 1) and should be completed by the supervisor before the visit.**
- 2) Notify your supervisor. Let he/she know what and where the mishap took place.**
- 3) The supervisor will notify the EFD/EFA Safety Manager (0526/09K) within 24 hours of the incident.**
- 4) The Supervisor or Safety Manager using, at a minimum, the investigation questionnaire attached below (Attachment 2) will investigate the mishap. The purpose of the investigation is to assure that the hazard is identified and eliminated so it won't happen to someone else.**
- 5) The supervisor will complete a CA – 1 form (Attachment 3) and forward to the EFD/EFA Safety Manager (0526/09K) for distribution to the applicable HRO department. It is important that the supervisor complete this form for all mishaps in order to protect each employee, even though there is no claim involved. Many times a medical condition resulting from a mishap may reoccur. If HRO has no record of an initial claim or report necessary leave for the employee may not be granted. Additional guidance may be obtained from the LANTDIVINST 12810.3A "Federal Employees' Injury Compensation Program" dated 9 SEP 1993 and LANTDIVINST 5100.17.**

ATTACHMENT # 1

DISPENSARY PERMIT
OPNAV 5100/9 (REV. 11-76)
S/N 0107-LF-051-0048

*PRIVACY ACT
STATEMENT ON REVERSE*

CASE NUMBER

SUPERVISOR'S REPORT		TO DISPENSARY (Location)	DATE OF REPORT	
EMPLOYEE'S NAME		TIME & DATE OF INJURY	TIME LEFT JOB	TIME RETURNED
SOCIAL SECURITY NO.	GRADE, RATE, JOB TITLE		OCCUPATIONAL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUESTIONABLE	
REASON FOR REFERRAL <input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS <input type="checkbox"/> EMPLOYEE'S REQUEST <input type="checkbox"/> OTHER (Specify)				
REMARKS				
SUPERVISOR'S SIGNATURE		SHOP/OFFICE	TELEPHONE NUMBER	
MEDICAL OFFICER'S REPORT		TIME REPORTED	TIME RELEASED	
OCCUPATIONAL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUESTIONABLE		TIME & DATE OF FIRST RE-TREATMENT	TIME & DATE OF SECOND RE-TREATMENT	
DEGREE OF INJURY <input type="checkbox"/> FIRST AID <input type="checkbox"/> DISPENSARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> PERSONAL PHYSICIAN <input type="checkbox"/> SENT HOME <input type="checkbox"/> OTHER (Explain)				
DISPOSITION OF EMPLOYEE				
<input type="checkbox"/> RETURN TO PERM. JOB _____		<input type="checkbox"/> TEMP. TRANSFER TO ANOTHER JOB		<input type="checkbox"/> TERMINATION OF EMPLOYMENT
<input type="checkbox"/> RESTRICT ACTIVITY UNTIL _____		<input type="checkbox"/> PERM. TRANSFER TO ANOTHER JOB		<input type="checkbox"/> OTHER (Explain)
REMARKS				
MEDICAL OFFICER'S SIGNATURE		INITIAL TREATMENT DETERMINATION <input type="checkbox"/> DISCHARGED, TREATMENT COMPLETED <input type="checkbox"/> RE-TREATMENT REQUIRED		

ATTACHMENT # 2



ACCIDENT INVESTIGATION FORM

(CASE NO. _____)

1. Employee's Name, Age, Grade, Code, & Job Title _____

2. Name of employee's supervisor _____

3. Time, date, and location of accident _____

4. What work assignment or activity was employee engaged in at time of accident? _____

5. Please describe the nature and extent of any injuries _____

6. What was the primary cause of this accident? _____

7. Was personnel error a factor? (i.e. haste, inattention, etc.) _____ If "yes", please describe. _____

8. Please describe any unsafe conditions involved. (i.e. wet floor, torn carpet, etc.) _____

What actions have been taken thus far to correct these conditions? _____

9. Please provide a brief summary of how the accident occurred. (A separate page may be used if necessary.) _____

10. Please indicate any recommendations to prevent accidents of this type from re-occurring. _____

11. Additional Comments. _____

ATTACHMENT # 3

Instructions for Completing Form CA-1

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

Employee (Or person acting on the employees' behalf)

13) Cause of Injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is

paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you change your election within one year, the agency is obliged to convert past periods of leave to COP, which qualify.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling 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 should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) 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).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

29) Was 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 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 whose defective product causes an employee's injury, could all be considered third parties to the injury.

31) 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.

32) First date medical care received

The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

- a) The disability results from an occupational disease or illness;
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is neither a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 90 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation 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, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus 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.

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)
- (2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.
- (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.
- (5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

- (1) The employing agency receives medical information from the attending physician to the effect that disability has terminated;
- (2) The OWCP advises that pay should be terminated; or
- (3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

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.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

Continuation of Pay/Compensation

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	
3. Date of birth	Mo.	Day	Yr.	4. Sex	5. Home telephone
				<input type="checkbox"/> Male <input type="checkbox"/> Female	()
7. Employee's home mailing address (Include city, state, and zip code)				6. Grade as of date of injury	
				Level	Step
				8. Dependents	
				<input type="checkbox"/> Wife, Husband	
				<input type="checkbox"/> Children under 18 years	
				<input type="checkbox"/> Other	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred	Time	11. Date of this notice	12. Employee's occupation
Mo. Day Yr.	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Mo. Day Yr.	

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

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation code	
	b. Type code	c. Source code
	OWCP Use - NOI Code	

Employee Signature

5. 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 or 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

Signature of employee or person acting on his/her behalf _____

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.

End of Employee Report

Witness _____

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

Supervisor's Report

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

OSHA Site Code _____
Zip Code _____

18. Employee's duty station (Street address and zip code) _____ Zip Code _____

19. Regular work hours From: a.m. p.m. To: a.m. p.m.
20. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

21. Date of injury Mo. Day Yr. _____
22. Date notice received Mo. Day Yr. _____
23. Date stopped work Mo. Day Yr. _____ Time: a.m. p.m.

24. Date pay stopped Mo. Day Yr. _____
25. Date 45 day period began Mo. Day Yr. _____
26. Date returned to work Mo. Day Yr. _____ Time: a.m. p.m.

27. Was employee injured in performance of duty? Yes No (If "No," explain) _____
28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

29. Was injury caused by third party? Yes No (If "No," go to item 31.)
30. Name and address of third party (include city, state, and zip code) _____

31. Name and address of physician first providing medical care (include city, state, zip code) _____

_____ 32. First date medical care received Mo. Day Yr. _____
33. Do medical reports show employee is disabled for work? Yes No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? Yes No (If "No," explain) _____
35. If the employing agency controverts continuation of pay, state the reason in detail. _____
36. Pay rate when employee stopped work \$ _____ Per _____

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, 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 _____

38. 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