

OBJECTIVE

This section provides direction on the roles of incident personnel in reporting and documenting injuries and illnesses on an incident, and authorizing medical treatment.

AUTHORITIES

There are 3 separate and distinct programs in this section, each with separate authorities. They are the federal workers' compensation program; Agency Provided Medical Care (APMC) program and state workers' compensation program.

RESPONSIBILITIESIncident agency responsibilities:

- Ensure that appropriate federal and state workers' compensation procedures outlined in this directive are implemented and followed.
- Provide a local contact and local guidelines/procedures for the Compensation/Claims Unit Leader (COMP).
- Providing local medical facility information.
- Establishing agreements or payment procedures with medical providers for APMC, if appropriate.

Incident Management Team (IMT) responsibilities:

- Provide appropriate and authorized medical attention to injured or ill individuals'.
- Forward claims per agency guidelines.

1 Finance/Administration Section Chief (FSC) responsibilities:
2

- 3 • Oversee the Compensation/Claims Unit to ensure appropriate
4 injury/illness treatment, authorizations, documentation, and timely
5 transmittal of information to the home unit.
6
7 • Ensure appropriate utilization of the APMC program and coordinating
8 with the Medical Unit Leader (MEDL), medical providers, the incident
9 agency, and others who may be involved.
10

11 Compensation/Claims Unit Leader or Compensation for Injury Specialist
12 responsibilities:

- 13
14 • Ensure the appropriate state or federal forms are properly completed for
15 all work related injuries or illnesses beyond first aid.
16
17 • Authorize medical treatment, as appropriate, using state workers'
18 compensation forms, form CA-16, Authorization for Examination or
19 Treatment, or form FS-6100-16, APMC Authorization and Medical
20 Report.
21
22 • Review medical treatment documentation for work restrictions and
23 informing the individual's supervisor of these restrictions.
24
25 • Ensure that necessary paperwork is completed, processed, forwarded
26 and faxed to the individual's home unit within established timeframes.
27
28 • Advise individuals' of their rights and responsibilities when injured or
29 ill.
30
31 • Provide information to the Time Unit Leader (TIME) for accurate
32 posting of timesheets for injured/ill individuals'.
33
34 • Provide information to the TIME for payroll deduction of non-work
35 related medical expenses.
36
37 • Follow up on the status of hospitalized or medical evacuated incident
38 personnel.
39
40 • Inform FSC and Safety Officer of injury/illness and trends occurring on
41 the incident.

Supervisor responsibilities:

- Obtain first aid/medical treatment for the injured person.
- Complete the supervisory portion of claim forms in a timely manner and giving receipt copy of the form to the injured person.
- Follow up with the Compensation/Claims Unit for work restrictions and follow-up medical treatment.
- Coordinate with the FSC and the Planning Section for work assignment modifications or recommendations for release from incident.
- Report time for injured/ill individual on a Crew Time Report (CTR).

Employee responsibilities:

- Request first aid or medical treatment if necessary.
- Notify supervisor of injury/illness.
- Complete employee portion of claim forms in a timely manner.
- Obtain witness statements.
- Promptly report time loss due to injury/illness to supervisor.

Home unit responsibilities:

- Follow applicable workers' compensation procedures in cases where follow-up medical care is required and/or when the injury or illness results in lost time beyond the date of injury.
- Submit claims and medical documentation, as appropriate, to the appropriate workers' compensation office in a timely manner.
- Handle all other case management responsibilities.

DEFINITIONS

Definitions used throughout this handbook are located in Appendix C – Glossary.

First Aid – First aid is emergency care or treatment given to an ill or injured person before regular medical care can be obtained. First aid is generally provided by someone other than a physician. On incidents, most first aid is provided in the field or camp by medical unit personnel such as Emergency Medical Technicians (EMTs). First aid cases involve no lost time.

Examples of first aid treatment include cleaning, flushing, or soaking wounds on the skin surface; using wound coverings such as bandages; using hot or cold therapy; using any totally non-rigid means of support such as elastic bandages, wraps, non-rigid back belts; using temporary immobilization devices while transporting an accident victim such as splints, slings, neck collars, or back boards; using eye patches; using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye; using finger guards; drinking fluids to relieve heat stress.

Medical Care – Treatment including managing and caring for a patient for the purposes of combating disease or disorder. Care is generally provided by a physician.

Examples of medical care include examination of the injured employee, stitches, x-rays, medical tests such as blood work, surgery, hospitalization, etc.

Occupational Disease or Illness – A condition produced by the work environment over a period longer than a single workday or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment (20 CFR Subpart A, 10.5(q); Office of Workers Compensation Programs (OWCP) Publication CA-810, 2-3).

Physician – The term “physician” includes doctors of medicine (MDs), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practices as defined by state law. Any treatment by a nurse practitioner or physician’s assistant must be countersigned by a physician as defined in the previous sentence and in Department of Labor (DOL) Publication CA-810.

1 Third-Party Case – An injury or illness/disease caused by a person or object
2 under circumstances that indicate there may be a legal liability on a party other
3 than the federal or state government. Contact the home unit for case
4 management advice.

6 Submission Requirements – Incident personnel will fax and mail the original
7 claim of injury or illness, along with supplemental information and medical
8 documentation, to the home unit or agency specific location within 2 days.

10 Traumatic Injury – A wound or other condition of the body caused by external
11 force, including stress or strain. The injury must be identifiable by time and
12 place of occurrence and member of the body affected; it must be caused by a
13 specific event or incident or series of events or incidents within a single day or
14 work shift (20 CFR Subpart A, 10.5(ee); OWCP Publication CA-810, 2-2).

16 **Federal Workers' Compensation**

18 **The Federal Employees' Compensation Act (FECA)**

20 The FECA provides compensation benefits to civilian employees of the United
21 States for disability due to personal injury or disease sustained while in the
22 performance of duty. The FECA is the exclusive remedy for federal workers
23 suffering a work related injury/illness. All related medical care including first
24 aid; physician services; surgery; hospitalization; drugs and medicines;
25 orthopedic, prosthetic, and other appliances and supplies are covered under the
26 FECA. The U.S. DOL OWCP administers the FECA (20 CFR Part 10). OWCP
27 has delegated agencies limited medical authorization authority through the
28 proper use of form CA-16, Authorization for Examination and/or Treatment.

30 **Coverage Under FECA**

32 Included in coverage are civilian federal employees of the United States
33 including those under a permanent, seasonal, temporary appointment, or casual
34 hire. Those excluded from coverage include contractors and employees of
35 contractors, inmate crews and their custodians, National Guard mobilized by a
36 Governor's order and active duty military personnel.

38 Generally, federal employees are covered under FECA while in travel status
39 away from their home unit unless they are engaged in non-work related
40 activities or deviate from the authorized course of travel for personal reasons. In
41 such cases, the individual may file a claim to obtain a determination from
42 OWCP. Do not authorize medical treatment in these circumstances.

Authorizing Medical Care

- Traumatic Injuries - OWCP has authorized agencies to issue form CA-16, Request for Examination and/or Treatment, to medical facilities/providers authorizing medical treatment for work related traumatic injuries. This form can only be issued once by the agency and provides for treatment up to 60 days, or until OWCP rules otherwise on the case. Issuance of the CA-16 allows the medical provider to refer the injured employee to specialists as necessary. CA-16 instructions direct the medical provider as to the type of treatment authorized and how to obtain further authorization from OWCP if necessary. The FSC, COMP, or the Injury Compensation Specialist (INJR) or other appropriate authorizing official may issue the CA-16 (Exhibit 16). The authorizing official shall ensure the appropriate U.S. DOL OWCP District Office address (based on the injured employee's personal home mailing address) is indicated in block 12 of the CA-16 (Exhibit 17).

If verbal authorization is given to the medical provider in an emergency situation, the CA-16 must be issued within 48 hours after the medical treatment is obtained.

When there is doubt whether the injury is work related check block 6.B.2 of the CA-16 to let the physician know of the concern.

- Occupational Disease or Illness – OWCP rarely allows agencies to authorize medical treatment related to an occupational disease or illness. The employee is responsible for the cost of treatment and can file a claim (CA-2, Notice of Occupational Disease and Claim for Compensation) with OWCP for adjudication of the claim. Do not complete a CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or issue a CA-16 for occupational disease or illness.

Continuation of Pay (COP)

- Definition and Entitlement. When a federal employee, including casuals, sustains a traumatic injury CA-1 is filed, (Exhibit 14) and seeks medical treatment from a physician, the individual may claim continuation of pay (COP) for any wage loss due to the injury. The intent of COP is to avoid interruption of the employee's income while the claim is being adjudicated by OWCP. A disability exists only when

1 determined by the physician and time loss must be documented by
2 medical records for an individual to be eligible for COP.
3

4 COP is available for a maximum of 45 calendar days and begins with
5 the first day or shift of disability or medical treatment after the date of
6 injury, provided the absence starts within 45 days after the injury. The
7 individual is responsible to coordinate with their home unit for specific
8 direction (20 CFR, Subpart B, 10.200 – 10.224; OWCP Publication
9 CA-810, 5-1).

10
11 COP may not be paid after a termination date that was established prior
12 to the injury. For casuals, COP ends when the casual leaves the
13 incident, the original length of commitments ends, or when the casual is
14 released back to duty, whichever occurs first.

15
16 There is no entitlement to COP for an occupational disease or illness.

- 17
- 18 • Controvert. In questionable situations, the agency may wish to
19 controvert (not pay) COP. The instructions on the back side of the CA-
20 1, item 36, identify the only reasons COP may be controverted. Any
21 issues beyond those described should be communicated to the home
22 unit for action.
 - 23
24 • COP Recording Procedures. Time loss due to disability and medical
25 treatment on the day of injury is not charged to COP. The individual is
26 kept in regular pay status to meet base hour requirements or paid the
27 guarantee hours (8, 9, or 10) for that calendar day. COP begins with
28 the first day of absence for disability or medical treatment following the
29 date of injury and should be identified on the Emergency Firefighter
30 Time Report, OF-288.

31
32 The only exception is when the injury occurs before the beginning of
33 the workday or shift. For example, while on incident assignment, an
34 individual is scheduled to work 0700-1900 and incurs a traumatic
35 injury at 0630. Medical treatment is provided and the physician notes
36 disability for that day. Charge COP for base hour requirements
37 beginning the shift immediately following the injury.
38

39 COP is charged for each day the individual is absent from work due to
40 disability including intermittent periods or partial days. For example,
41 an individual is treated and released by the doctor to return to work on
42 the date of the injury, but is required to return for follow-up treatment

1 during regular work hours on a subsequent day. Use COP to pay time
2 for this follow-up treatment.

3
4 Work performed during a period of COP is recorded as regular hours of
5 work. Return travel to the home unit from an incident assignment is
6 considered work time and is not charged to COP.

7
8 Travel to and from a medical provider and/or time spent receiving
9 medical treatment is compensable as work hours if it falls within the
10 normal guaranteed work schedule (guaranteed 8 hour day for casuals).
11 FECA does not allow payment of overtime for either of these activities.

12 13 COP Recording for Regular Government Employees

14 The COP rate for a regular government employee is determined by
15 the individual's home unit.

16
17 To record COP, indicate "COP" in the Start/Stop columns.
18 Record, in the Hours column, the total time needed to complete the
19 guarantee hours (8, 9, or 10) for that day. Indicate partial days of
20 disability with clock hours and total COP hours in the Hours
21 column. Note date and time of injury and return to duty
22 information in the Remarks block (Exhibit 20).

23 24 COP Recording for casuals

25 For casuals the COP rate is determined by the AD position
26 classification the casual was working under at the time of injury.

27
28 To record COP, indicate "COP" in the Start/Stop columns and
29 record "8" in the Hours column for each full day of disability.
30 Indicate partial days of disability with clock hours and total COP
31 hours in the Hours column. Note date and time of injury and
32 related information in the Remarks block.

1 Example:

2
3 A PTRC (single resource) is injured on day 8 of a 14 day
4 assignment, the disability continues for another 8 days, the
5 PTRC would only be entitled to 6 days of COP.

6
7 A Type 2 crew member is injured on day 5 and released home.
8 On day 10, the crew member was released by his physician to
9 return to duty, but the rest of the crew completed the 14 day
10 assignment. The crew member would only be entitled to 5 days
11 COP. A casual is only entitled to COP, until released by a
12 physician, not to exceed 45 days.

13
14 If on a day subsequent to the date of injury and initial treatment,
15 a casual worked 4 hours and was then transported to a doctor for
16 follow-up treatment (2 hours round trip travel and medical
17 treatment time), the COP entitlement would be 2 hours (4 hours
18 work + 2 hours travel/medical + 2 hours COP = 8 hours
19 guarantee). The 2 hours of medical time is compensable as work
20 time as it falls within the guaranteed 8 hours. Record "COP" in
21 the Start/Stop columns and "2" in the Hours column.

22
23 If a casual works 8 or more hours prior to seeking medical
24 treatment, there is no charge to COP for the day. If the casual is
25 assigned work during the time under medical restrictions, this
26 time is not COP and must be recorded as regular work time,
27 whether within or exceeding 8 hours of compensation for the
28 day.

29
30 Do not confuse COP with the guaranteed 8 hours per day for
31 casuls. They are 2 different sets of guidance for entirely
32 different purposes. For instance, COP is not allowed for an
33 occupational disease or illness. However, if a casual has a cold
34 and misses work, the casual may still be entitled to their
35 guaranteed 8 hours of pay if not released from the incident.

36 37 **Selection of Physician**

38
39 Under FECA, employees may elect a physician of their choice. Emergency
40 incidents that dictate securing medical services from the nearest available
41 facility does not constitute selection or choice of physician. The election is still

1 available, should further treatment be necessary, when the employee returns to
2 the home unit.

4 **Agency Provided Medical Care (APMC)**

6 This is a program under which the agencies pay for limited costs for minor
7 injuries or illnesses that involve only one treatment. One possible follow up
8 visit is permissible if it occurs during non duty hours and the employee is
9 agreeable to this.

11 This coverage is separate from the provisions of the FECA. APMC should not
12 interfere with employee's rights under FECA for treatment of work related
13 injuries and illness. Treatment under APMC may be disadvantageous to the
14 employee and the COMP/INJR is responsible to counsel the employee on their
15 options. Because OWCP has a fee schedule, costs associated with claims
16 through FECA are significantly lower than APMC treatment costs.

18 **Authority for APMC**

20 The Department of Agriculture Organic Act of September 21, 1944, and the
21 Granger-Thye Act of April 24, 1950 authorize appropriated funds to be used to
22 purchase necessary medical supplies, services, and other assistance for the
23 immediate relief of individuals' engaged in hazardous work. These authorities
24 should not be interpreted to circumvent OWCP procedures for FECA, which
25 provides the exclusive remedy for medical care and other benefits related to all
26 work-related injury or illness.

28 **APMC Coverage**

30 Appropriate Use – The use of APMC is appropriate for injury/illness cases
31 involving only 1 APMC visit which occurs on the day of the injury/illness. One
32 follow-up visit is permissible if it occurs during non-duty hours and the
33 employee is agreeable to this. APMC can only be used while the employee
34 remains at the site of the incident. Injury/illness cases treated under APMC
35 cannot have lost time charged to sick leave, annual leave, or (COP). If initial
36 treatment by a medical provider occurs after the date of injury, follow-up
37 treatment is necessary after the individual is released from the incident, and/or
38 lost time occurs or is expected, the claim must be processed under FECA.

1 Medical treatment for traumatic injury claims are most appropriately processed
2 following the FECA procedures described earlier, rather than APMC
3 procedures. This will establish a record for the employee with OWCP and
4 provides the greatest protection and timely service should further treatment be
5 necessary upon return to the home unit.

6
7 Employee Choice of Processes – Injured federal employees do not have a right
8 to treatment under APMC as they do under FECA. It is the agency's choice
9 whether or not to offer APMC. Per OWCP, the employee's use of APMC
10 instead of FECA is voluntary. The COMP/INJR is responsible to counsel the
11 employee on the difference between APMC and OWCP treatment and allow the
12 employee to choose.

13
14 APMC Use for Treatment of Traumatic Injuries – Use of APMC for traumatic
15 injuries must be limited to injury/illness cases involving only 1 treatment and
16 may not include authorization for therapy, stitches, x-rays, or other non-first aid
17 treatments.

18
19 APMC Use for Treatment of Occupational Disease & Illness Claims – APMC
20 may be used to authorize first aid treatment only for illnesses such as respiratory
21 infections, colds, sore throats and similar conditions associated with exposure to
22 smoke, dust, and weather conditions, etc. Authorization of APMC treatment is
23 at the discretion of the agency and should be minimal, only to relieve suffering.
24 APMC is appropriate as an interim measure until the employee can arrange for
25 private medical attention, at the individuals' expense, or file a claim under
26 FECA and await OWCP's approval to incur medical expenses.

27
28 Non-Work Related Injuries/Illness – APMC should not be authorized for non-
29 work related injuries or illnesses. However, in situations where it is deemed
30 necessary by the incident agency, counsel the employee and ensure that a
31 payroll deduction is made to cover the cost. The incident agency is responsible
32 for paying the medical provider and for resolving any disputed matters with the
33 individual treated for all APMC services authorized.

34
35 APMC Use for Dental Work – Do not authorize APMC for dental treatment,
36 e.g., toothache due to cavity, where there is any question whether it relates to a
37 work related injury. Upon return to the home unit, the individual can obtain
38 treatment and file a claim for reimbursement from OWCP if they feel the
39 condition was work related. However, in situations where it is deemed
40 necessary by the incident agency, counsel the employee and ensure that a
41 payroll deduction is made to cover the cost.

1 Contractors – Contract personnel may not utilize APMC services.

2
3 State and Other Non-Federal Employees –State authorities vary and may not
4 allow APMC for state employees. The sending unit geographic area state or
5 federal incident business management coordinator should be contacted for the
6 states policy in this matter if the injured individual does not have the
7 information (State and National Guard employees’ coverage is dependent on
8 the contract and/or agreement under which they are dispatched).

9
10 Military Personnel – Military medical units will provide treatment for military
11 personnel (Military Use Handbook, Chapter 100).

12 13 **Procedures to Establish APMC**

14
15 The FSC coordinates the establishment of APMC through the incident agency.

16 17 **Payment of APMC Costs**

18
19 Appropriate APMC costs, as authorized by the FSC or COMP, are paid by
20 incident personnel or the incident agency per agency policy.

21 22 **Procedures for Using APMC**

23
24 Medical Resource Request Number – A medical resource request number (M#)
25 is assigned for treatment under APMC. The M# is issued to the medical
26 provider by the Finance/Administration Section. Requests are numbered
27 sequentially, prefixed by the resource category alpha code, e.g., M-1, M-2, M-3.
28 Each incident is assigned a unique incident/project order number. For example,
29 MT-LNF-076 stands for: Montana, Lolo National Forest. The “076” is the
30 sequential incident number. The medical resource request number consists of
31 the incident order number, followed by the request number, e.g., MT-LNF-076,
32 M-1. This combination is referred to as an M#. One M# is issued to cover
33 APMC treatment associated with a specific injury or illness.

34
35 COMP or INJR issues the APMC Authorization and Medical Report, Form FS-
36 6100-16, which is used to authorize APMC treatment and for the medical
37 provider to document patient evaluation and diagnosis. The FS-6100-16 is
38 returned to the COMP/INJR so duty status and disability determinations can be
39 made.

40
41 All APMC cases must have the M# entered on the top of all reporting forms
42 with a notation “Paid by APMC”.

1 All authorized services must be summarized on the Incident Injury/Illness Log.
2 The FSC/COMP provides a copy of the log to the incident agency to support
3 payment for APMC and to facilitate follow-up (Exhibit 19).

4
5 Do not confuse APMC procedures with either state or federal workers'
6 compensation programs. Do not issue a form CA-16, Authorization for
7 Examination and Treatment for APMC.

9 **Procedures and Documentation Requirements for FECA or APMC**

11 **Traumatic Injury**

12
13 **Form Required** – CA-1, Report of Traumatic Injury and Claim for
14 Compensation.

16 **Action Taken:**

- 17
18 ○ Individual completes the front of form as soon as possible and
19 preferably within 48 hours of the injury. Supervisor completes the
20 reverse side, signs, and gives receipt to individual.
- 21
22 ○ Individual/supervisor should obtain witness statement(s) if
23 appropriate. Supervisor is responsible for completion if employee
24 is incapacitated.
- 25
26 ○ Leave blocks titled “Occupational code”, “Type code”, “Source
27 code”, “OWCP Agency Code”, and “Occupational Safety and
28 Health Administration (OSHA) Site Code” blank. Home unit is
29 responsible to complete.
- 30
31 ○ INJR advises individual of rights, benefits, and responsibilities.
- 32
33 ○ INJR authorizes medical care, if appropriate, by issuing:
 - 34
35 ■ If using FECA procedures: CA-16, Authorization for
36 Examination and/or Treatment, if the case requires any
37 medical treatment. Only 1 form per injury is issued to the
38 medical provider. OR;
 - 39
40 ■ If using APMC procedures: FS-6100-16, APMC
41 Authorization and Medical Report for 1 first aid type of
42 treatment. If a follow-up appointment, after duty hours, is

1 required, INJR issues another FS-6100-16. The original
2 M number is used for a follow up visit.

- 3
- 4 ▪ If verbal authorization is given to the medical provider,
5 forward the authorization form to provider within 48
6 hours.
- 7

- 8 ○ Injured individual or individual acting on their behalf returns
9 completed form to the INJR.
- 10
- 11 ○ COMP/INJR faxes **and** mails original injury/illness forms,
12 supporting documentation and medical treatment records to the
13 individual's home unit compensation specialist within 2 days of
14 receipt of the CA-1.
- 15

16 **Occupational Disease (Illness)** covered by FECA requiring medical treatment
17 or resulting in lost time.

18

19 **Form Required** – CA-2, Notice of Occupational Disease and Claim for
20 Compensation.

21

22 **Action Taken:**

- 23
- 24 ○ Individual completes the front of form as soon as possible and
25 preferably within 48 hours. Supervisor completes and signs
26 reverse side.
- 27
- 28 ○ Leave blocks titled "Occupational code", "Type code", "Source
29 code", "OWCP Agency Code", and "OSHA Site Code" blank.
30 Home unit is responsible to complete.
- 31
- 32 ○ INJR advises individual of rights, benefits, and responsibilities.
- 33
- 34 ○ INJR authorizes appropriate APMC medical care, using a FS-
35 6100-16, for first aid treatment for illnesses such as respiratory
36 illness, colds, sore throats and similar conditions associated with
37 exposure to smoke, dust, and weather conditions, etc. Treatment
38 of more significant illness/disease conditions are not authorized
39 and must be submitted to OWCP for adjudication. Do not issue a
40 CA-16 for an occupational disease or illness.

- 1 ○ COMP/INJR faxes **and** mails original injury/illness forms,
2 supporting documentation and medical treatment records to the
3 individual's home unit compensation specialist within 2 days of
4 receipt of the CA-2.
5

6 **Prescriptions** – Utilize local pharmacies that accept the DOL, OWCP fee
7 schedule and bill directly. Pharmacies/Medical providers not enrolled with
8 DOL, OWCP, Division of Federal Employees Compensation (DFEC), should
9 contact DOL, Affiliated Computer Services (ACS) <https://owcp.dol.acs-inc.com>.

10
11 **Fatality** – The individual's home unit processes workers' compensation claim.
12 If death is not immediate incident finance personnel takes the following actions;
13

- 14 • **Forms Required** – If death is not immediate
15 ○ CA-1, Report of Traumatic Injury and Claim for Compensation
16 ○ CA-16, Authorization for Examination and/or Treatment, if
17 appropriate
18 ○ **Action Taken:**
19 ○ COMP/INJR authorizes medical care, as appropriate under FECA
20 regulation, utilizing the CA-16, Authorization for Examination
21 and/or Treatment, if employee is transported to medical facility to
22 be treated before death is declared. (CA-16's should not be issued
23 for any type of illness or injury that, even though life-threatening,
24 is not clearly work related. Seizures, chest pains, stroke
25 symptoms, or unexplained loss of consciousness are not clearly
26 work related, and a CA-16 should not be issued).
27 ○ Supervisor completes the front and back of the CA-1 form as soon
28 as possible.
29 ○ Leave blocks titled "Occupational code", "Type code", "Source
30 code", "OWCP Agency Code", and "OSHA Site Code" blank.
31 Home unit is responsible to complete.
32 ○ COMP/INJR faxes all forms and supporting documentation
33 (medical reports, accident investigation report, witness statements,
34 etc.) to the home unit **immediately upon receipt**, and mails
35 original injury/illness forms, supporting documentation to the
36 individual's home unit compensation specialist within 2 days of
37 receipt.
38 ○ COMP/INJR faxes all forms and supporting documentation
39 (medical reports, accident investigation report, witness statements,
40 etc.) to the home unit **immediately upon receipt**, and mails
41 original injury/illness forms, supporting documentation to the
42 individual's home unit compensation specialist within 2 days of
43 receipt.

Forms Distribution

Federal agencies are required to submit workers' compensation claims documents to OWCP within 10 days of the date signed by the employee. In order for home units to comply, the COMP/INJR faxes **and** mails original injury/illness forms, supporting documentation and medical treatment records to the individual's home unit compensation specialist within 2 days of receipt of the CA-1/CA-2. This allows the home unit to review the information, contact the incident if clarification is necessary, meet OWCP reporting requirements and ensure injured workers receive timely and quality service. A temporary copy may be retained by the Compensation/Claims Unit during the incident, but must be either sent home with the employee or destroyed prior to the end of the incident.

The Compensation/Claims Unit Leader:

- Uses the Incident Injury Case File Envelope to file injury forms, supporting documentation, and medical treatment documentation. Forward the complete package to the individual's home unit upon demobilization of the individual (Exhibit 22).
- Completes an Incident Injury/Illness Log to document injuries/illnesses. The log may not contain any sensitive information (Exhibit 19).

All compensation for injury documents are protected by the Privacy Act and shall not be retained in the incident records. When original documents are forwarded to the home unit or other location as specified, all temporary copies are sent home with the employee or destroyed. Retain the Incident Injury/Illness Log in the incident records.

State and Cooperators Workers' Compensation Coverage

- State Workers' Compensation – State employees experiencing injury or illness on the incident should complete state specific forms and notify their home unit of workers' compensation claims per agency requirements. If state forms are not available, the employee may use a CA-1 or CA-2 to initially record the necessary information. Federal references should be crossed out and the state name written at the top of the form. The state employee is responsible to contact the home unit to obtain the proper reporting forms. The COMP maintains injury compensation records and transmits documents to the home unit per

1 state agency policy. Do not issue CA-16 for medical treatment.
2 Reference APMC coverage.

- 3
- 4 • Cooperators – Cooperators are normally covered under their home unit
5 workers' compensation program, e.g., state, county, local government.
6 Cooperators experiencing injury or illness on the incident should
7 complete home unit specific forms and notify their home unit of
8 workers' compensation claims per their agency requirements. The
9 COMP maintains injury compensation records and transmits
10 documents to the home unit per cooperator agency policy.

11

12 If a cooperator is hired as a federal casual, follow FECA or APMC
13 procedures as appropriate. If a cooperator is hired as a state employee,
14 follow state workers' compensation procedures.

15

16 Federal agencies entering into cooperative agreements do not have the
17 authority to grant FECA coverage to individual cooperators. Some
18 cooperative agreements require reimbursement for medical costs. This
19 should not be interpreted as providing coverage under FECA.

20

21 **EXHIBITS**

- 22
- 23 • Exhibit 14 – Notice of Traumatic Injury and Claim for Continuation of
24 Pay/Compensation (CA-1)
 - 25 • Exhibit 15 – Notice of Occupational Disease and Claim for
26 Compensation (CA-2)
 - 27 • Exhibit 16 – Authorization for Examination and/or Treatment (CA-16)
 - 28 • Exhibit 17 – U.S. Department of Labor OWCP District Offices List
 - 29 • Exhibit 18 – Agency Provided Medical Care (APMC) Authorization and
30 Medical Report (FS-6100-16)
 - 31 • Exhibit 19 – Sample Incident Injury/Illness Log
 - 32 • Exhibit 20 – Emergency Firefighter Time Report (OF-288) Showing COP
33 for a Regular Government Employee
 - 34 • Exhibit 21 – Emergency Firefighter Time Report (OF-288) Showing COP
35 for a Casual Employee
 - 36 • Exhibit 22 – Sample Incident Injury Case File Envelope (OF-313)

EXHIBIT 14
NOTICE OF TRAUMATIC INJURY AND CLAIM FOR
CONTINUATION OF PAY/COMPENSATION, CA-1

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
 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.

1. Name of employee (Last, First, Middle) **Smith, Katrina L** 2. Social Security Number **000-00-0000**

3. Date of Birth (Mo. Day Yr.) **XX/XX/XX** 4. Sex Male Female 5. Home Telephone (include area code) **208-555-1234** 6. Grade as of date of injury
 Level **7** Step **2**

7. Employee's home mailing address (include city, state, and zip code)
123 Waterway Rd
Boise, ID 83705 8. Dependents
 Wife, Husband
 Children under 18 years
 Other

Description of Injury
 9. Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
Warm Lake Incident Base - Tool Sharpening Area

10. Date Injury Occurred (Mo. Day, Yr.) **07/12/2008** Time **10:15** a.m. p.m. 11. Date of this notice (Mo., Day, Yr.) **07/12/2008** 12. Employee's Occupation **Forestry Technician**

13. Cause of Injury (Describe what happened and why.)
While sharpening a shovel, my hand slipped and my right thumb ran across the shovel's edge.

14. Nature of Injury (Identify both the injury and the part of body, e.g., fracture of left leg)
Right thumb laceration

a. Occupation code		
b. Type code	c. Source code	
OWCP Use-NOI Code		

Employee Signature

15. 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:
 a. 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.
 b. Sick and/or Annual Leave
 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.

Signature of employee or person acting on his/her behalf Date **7/12/2008**
 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 penalties 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.
Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)
I was working beside Katrina and I saw her cut her right thumb on a shovel edge.

Name of witness Piper Lynn	Signature of witness 	Date signed 07/12/2008	
Address PO Box 3333	City Boise	State ID	Zip Code 83704

EXHIBIT 14 - Continued

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) OWCP Agency Code
 BLM - Boise District Office

3924 Development Avenue OSHA Site Code

Boise ID 83705

18. Employee's duty station (Street address and ZIP code)
 BLM - Boise District Office 3924 Development Avenue Boise ID 83705

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: 09:00 a.m. To: 06:00 a.m. 21. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of injury 07/12/2008 23. Date notice received 07/12/2008 24. Date stopped work 07/12/2008 Time: 10:15 a.m. p.m.

25. Date pay stopped 26. Date 45 day period began 07/13/2008 27. Date returned to work 07/14/2008 Time: 04:00 a.m. p.m.

28. Was employee injured in performance of duty? Yes No (if "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (if "Yes," explain) No

30. Was injury caused by third party? Yes No (If "No," go to item 32.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)
 Dr. Converse
 1313 Water Street
 Boise ID 83705

33. First date medical care received 07/12/2008

34. Do medical reports show employee is disabled for work? Yes No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (if "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.
 N/A

37. Pay rate when employee stopped work \$ 17.70 Per hour

Signature of Supervisor and Filing Instructions

38. 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)
 Laine Schwarberg

Signature of supervisor *Laine Schwarberg* Date 07/12/2008

Supervisor's Title Supply Unit Leader Office phone (208) 555-1212

39. Filing instructions No lost time and no medical expense: Place this form in employee's medical folder (SF-65-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

Form CA-1
 Rev. Apr. 1989

EXHIBIT 14 - Continued

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 filed CA-1 within thirty days of the injury, you may be 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. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

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 39, 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.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) 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.

32) 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.

33) First date medical care received

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

36) If the employing agency controverts continuation of pay, state the reason in detail.

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 was not caused by a traumatic injury.
- 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 not 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 45 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.

EXHIBIT 15
NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION, CA-2

Notice of Occupational Disease and Claim for Compensation

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



Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data
1. Name of employee (Last, First, Middle) Ruby, Tim S.
2. Social Security Number 000-00-0000
3. Date of birth Mo. Day Yr. 7 12 59
4. Sex M
5. Home telephone (208) 555-1111
6. Grade as of date of last exposure Level 6 Step 5
7. Employee's home mailing address (include city, state, and zip code) 285 Smoke Street Boise ID Zip code 83705
8. Dependents: [X] Wife, Husband; [] Children under 18 years; [] Other
9. Employee's occupation: Forestry Technician
a. Occupation code
10. Location (address) where you worked when disease or illness occurred (include city, state, and zip code) Paper Fire on the Boise National Forest 1275 Oakwood Road
11. Date you first became aware of disease or illness Mo. Day Yr. 8 22 8
12. Date you first realized the disease or illness was caused or aggravated by your employment Ma. Day Yr. 8 22 8
13. Explain the relationship to your employment, and why you came to this realization

While working as a firefighter on the Paper Fire, I was subjected to a great amount of smoke inhalation. The smoke was caused by a slip over in the area where I was working.

14. Nature of disease or illness: Smoke Inhalation
OWCWP Use - NOI Code: b. Type code; c. Source code
15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay: N/A
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay: N/A
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay: N/A

Employee Signature
18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.
Signature of employee or person acting on his/her behalf: [Signature] Date: 8/22/08
Have your supervisor complete the receipt attached to this form and return it to you for your records.
Any person who knowingly makes 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 felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

EXHIBIT 15 - Continued

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

Supervisor's Report											
19. Agency name and address of reporting office (include city, state, and ZIP Code)										OWCP Agency Code	
USFS, ASC-HCM Workers' Compensation Section											
3900 Masthead St., MS-118										OSHA Site Code	
Albuquerque NM 87109										ZIP Code	
20. Employee's duty station (Street address and ZIP Code)										ID	
NFC 3833 S. Development Avenue Boise										83705	
21. Regular work hours				22. Regular work schedule							
From: 09:00 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.				To: 06:00 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.				Sun. <input type="checkbox"/> Mon. <input checked="" type="checkbox"/> Tues. <input checked="" type="checkbox"/> Wed. <input checked="" type="checkbox"/> Thurs. <input checked="" type="checkbox"/> Fri. <input type="checkbox"/> Sat.			
23. Name and address of physician first providing medical care (include city, state, ZIP code)										24. First date medical care received	
Cascade Medical Center										Mo. Day Yr.	
4720 Deer Lane											
Cascade ID 88603										25. Do medical reports show employee is disabled for work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Date employee first reported condition to supervisor				27. Date and hour employee stopped work							
Mo. Day Yr. 08/22/2008				Mo. Day Yr. 08/22/2008				Time 02:00 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.			
28. Date and hour employee's pay stopped				29. Date employee was last exposed to conditions alleged to have caused disease or illness							
Mo. Day Yr. Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.				Mo. Day Yr. 08/22/2008							
30. Date returned to work				31. If employee has returned to work and work assignment has changed, describe new duties							
Mo. Day Yr. 08/23/2008				Time 08:00 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.				Employee assigned light duty at the incident base and is not to be exposed to smoke for two days. Employee can return to fireline after two days.			
32. Employee's Retirement Coverage <input type="checkbox"/> CSRS <input checked="" type="checkbox"/> FERS <input type="checkbox"/> Other, (Specify)											
33. Was injury caused by third party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				34. Name and address of third party (include city, state, and ZIP code)							
If "No," go to item 34.											
Signature of Supervisor											
35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.											
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:											
Name of Supervisor (Type or print) Tammy Bull											
Signature of Supervisor <i>Tammy Bull</i>										Date 08/22/2008	
Supervisor's Title Strike Team Leader										Office phone (208)355-1234	

Form CA-2 Rev. Jan. 1997

EXHIBIT 16
AUTHORIZATION FOR EXAMINATION
AND/OR TREATMENT, CA-16

Authorization for Examination
 And/Or Treatment

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



The following request for information is authorized by law (5 USC §101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cf. No. A-108.

OMB No.: 1215-0103
 Expires: 09/30/91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service: Dr. Converse 1313 Water Street Boise, ID 83705			
2. Employee's Name (last, first, middle) Miller, Amy K.	3. Date of Injury (mo., day, yr.) 7/12/03	4. Occupation Forestry Technician	
5. Description of Injury or Disease: Right Thumb Laceration			

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 8 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B 1. I furnish office and/or hospital treatment as medically necessary for the effects of the injury. Any surgery other than emergency must have prior OWCP approval.

2. There is doubt whether the Employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)

8. Signature of Authorizing Official:

9. Name and Title of Authorizing Official: (Type or print clearly)

Sissal Batey
 Comp/Claims Unit Leader

10. Local Employing Agency Telephone Number:
 (208) 555-0123

11. Date (mo., day, year)
 7/12/03

12. Send one copy of your report (Fill in remainder of address)

13. Name and Address of Employee's Place of Employment:

Department or Agency
 U. S. Department of Interior
 Bureau or Office
 Bureau of Land Management
 Local Address (Including Zip Code)
 3524 Development Avenue
 Boise, ID 83705

U.S. DEPARTMENT OF LABOR
 Employment Standards Administration
 Office of Workers' Compensation Programs
 1111 Third Avenue, Suite 550
 Seattle, WA 98101-3212

(See Exhibit 04 for OWCP District Office list)

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 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. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20219, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

This form was a sectionally produced by National Production Service Staff

Form CA-16
 Rev. Oct. 1988

EXHIBIT 17

US DEPARTMENT OF LABOR OWCP DISTRICT OFFICES

US DEPARTMENT OF LABOR DISTRICT OFFICES

<p><u>District Office 1 – Boston</u> (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) U.S. Dept. of Labor, OWCP JFK Federal Building, Room E-260 Boston, MA 02203</p>	<p><u>District Office 11 – Kansas City</u> (Arkansas, Iowa, Kansas, Missouri, and Nebraska; all employees of the Department of Labor, except Job Corps enrollees, and their relatives) U.S. Dept. of Labor, OWCP Two Pershing Square Building 2300 Main Street, Suite I 090 Kansas City, MO 64108-2416</p>
<p><u>District Office 2 – New York</u> (New Jersey, New York, Puerto Rico, and the Virgin Islands) U.S. Dept. of Labor, OWCP 201 Varick Street, Room 740 New York, NY 10014</p>	<p><u>District Office 12 – Denver</u> (Colorado, Montana, No. Dakota, So. Dakota, Utah, and Wyoming, New Mexico) U.S. Dept. of Labor, OWCP One Denver Federal Center, Building 13 Denver, CO 80225-0602</p>
<p><u>District Office 3 – Philadelphia</u> (Delaware, Pennsylvania, and West Virginia; Maryland when the claimant's residence has a zip code beginning with 21***) U.S. Dept. of Labor, OWCP Curtis Center, Suite 715 East 170 S. Independence Mall West Philadelphia, PA 19106-3308</p>	<p><u>District Office 13 – San Francisco</u> (Arizona, California, Hawaii, and Nevada) U.S. Dept. of Labor, OWCP 90 Seventh St., Suite 15300 San Francisco, CA 94103</p>
<p><u>District Office 6 – Jacksonville</u> (Alabama, Florida, Georgia, Kentucky, Mississippi, No. Carolina, So. Carolina, and Tennessee) U.S. Dept. of Labor, OWCP 400 West Bay Street, Room 826 Jacksonville, FL 32202</p>	<p><u>District Office 14 – Seattle</u> (Alaska, Idaho, Oregon, and Washington) U.S. Dept. of Labor, OWCP 300 Fifth Avenue, Ste 1050 Seattle, WA 98104</p>
<p><u>District Office 9 – Cleveland</u> (Indiana, Michigan, Ohio; All special claims and all areas outside of the U.S., Its possessions, territories and trust territories) U.S. Dept. of Labor, OWCP 1240 East Ninth Street, Room 851 Cleveland, OH 44199</p>	<p><u>District Office 16 – Dallas</u> (Louisiana, Oklahoma, and Texas) U.S. Dept. of Labor, OWCP 525 South Griffin Street, Room 100 Dallas, TX 75202</p>
<p><u>District Office 10 – Chicago</u> (Illinois, Minnesota, Wisconsin) U.S. Dept. of Labor, OWCP 230 South Dearborn Street, Eighth Floor Chicago, IL 60604</p>	<p><u>District Office 25 – Washington D.C.</u> (District of Columbia, Virginia, Maryland when the claimant's residence has a zip code other than 21***) U.S. Dept. of Labor, OWCP 800 N. Capital Street N.W., Room 800 Washington, D.C. 20211</p>

EXHIBIT 18
AGENCY PROVIDED MEDICAL CARE (APMC) AUTHORIZATION
AND MEDICAL REPORT, FS-6100-16

USDA-Forest Service		FS 6100-16 (01/05)
AGENCY PROVIDED MEDICAL CARE AUTHORIZATION AND MEDICAL REPORT (Physician or Medical Facility Form may be used for Medical Report) (Refer to FSH 5109.34, IBMH Chptr 10)		
Part A Authorization		
1. Medical Resource Request "M Number"		
M-2		
2. Procurement Identification (BPA/Field PO No., etc)		
3. Responsible Payment Unit		
Boise National Forest		
4. Employee Name	6. Social Security No.	
Tim Ruby	XXX-XX-XXXX	
6. Employing Agency	8. Date of Injury	
Forest Service, Boise National Forest	08/22/XXXX	
7. Home Unit and Address		
Boise National Forest 1275 Oakwood Road Boise, ID 87045		
9. Physician/Medical Facility:		
<u>Cascade Medical Center</u> <u>4720 Deer Lane</u> <u>Cascade, ID 88603</u>		
9a Description of Injury or Disease:		
Smoke Inhalation		
Please provide initial diagnosis and treatment medically necessary for Injury/Illness. Surgery, other than emergency, and/or hospitalization requires further authorization. Please complete the following medical report at the time of treatment and give to the employee for return to our office.		
10. Authorizing Signature (Agency Admin/Line Officer, FSC, or COMP)	11. Date	
<i>Courtney Cray, COMP</i>	08/22/XXXX	
Part B Attending Physician's Report		
1. Evaluation or Diagnosis:		
Smoke inhalation resulting in a bronchial infection		
2. Description of Treatment:		
Bronchial therapy and medication		
3. Medicine Prescribed and Potential Side Effects:		
10 days antibiotics		
4. Work Restrictions (if any) and length of restrictions.		
Do not expose to smoke for 2 days – then can return to fireline duty. Can work in a non-smoky environment.		
5. Physician's Signature	6. Date	
<i>Doctor Signature, MD</i>	08/22/XXXX	
Attachment: Employee's CA-1/CA-2 (white copy) OVER Medical Facility CA-1/CA-2 (pink copy) Incident Unit Headquarters CA-1/CA-2 (yellow copy)		

EXHIBIT 18 - Continued

Employing Office Instructions

Medical treatment for this injury/illness was provided by our Agency through procurement with medical providers under the *Agency Provided Medical Care (APMC)* program. These procedures are entirely apart from and not under the authority or provisions of FECA/OWCP, and do not require issuing a CA-16. However, a CA-1 or CA-2 was completed in all cases for the employee's protection.

Do not pay invoices or statements attached to CA forms. Do not forward to OWCP for payment if:

(1) no further medical treatment is necessary, (2) there is no lost time due to the injury/illness, and (3) this initial treatment did not involve surgery or hospitalization. Under these circumstances only, file the CA-1/CA-2 and medical documentation in the Employee's Medical Folder for record purposes.

If any one of the following conditions occurs, initiate appropriate OWCP procedures:

1. For lost time cases which occurred on the incident assignment or following the employee's return (and are supported by the attached medical documentation), but no further medical treatment is required, submit CA-1/CA-2 and the medical report from the medical provider to OWCP as part of the claim package. Provide explanation to OWCP that all medical services were paid by the Agency. Grant COP and provide form CA-3 to OWCP as appropriate in traumatic injury cases.

2. Where emergency surgery or hospitalization was provided by the medical facility in conjunction with APMC, submit CA-1/CA-2 and the medical reports to OWCP as outlined in item 1 above.

3. Where followup treatment is necessary or there is loss of wages, follow standard OWCP procedures. This includes issuing CA-16 as appropriate to the physician of the employee's choice. File the claim with your OWCP District Office.

Situations may arise where the physician provided by this Agency determined that the employee was fit for light or regular duty and subsequent evaluation shortly thereafter by the physician selected by the employee indicates the employee is disabled. While this requires resolution by OWCP, the employee must receive continuation of pay, if other requirements for COP are met, pending OWCP's decision.

If you have any questions or problems, please contact Incident Unit Headquarter's Compensation Specialist:

Comp Specialist Name	Connie Comp
Agency Unit Headquarters	R4 USFS
Phone Number	(XXX) XXX-XXXX

EXHIBIT 20
EMERGENCY FIREFIGHTER TIME REPORT (OF-288) SHOWING COP
FOR A REGULAR FEDERAL EMPLOYEE

EMERGENCY FIREFIGHTER TIME REPORT F711
2. Social Security Number: 000-00-0000
3. Initial Employment (X One): Yes
4. Type of Employment (X One): Regular Gov't Employee
6. Transferred from:
7. Employee Has (X One): Been Discharged, Quit
8. Entitled to Return Travel Time (X One): Yes
9. Entitled to Return Transportation (X One): Yes
10. Name (First, Middle, Last): Smokey T. Bear
11. Street Address: 118 W Smokey Bear Blvd
12. City: Boise
13. State: ID
14. Zip Code: 83705
16. Name: Sue Bear
17. City: same
20. FIRE LOCATION IDENTIFICATION
1. Fire Name: Warm Lake
2. Fire No.: ID-BOD-005161
3. Unit Code: BOD
4. Fire Location: ID
5. State: ID
6. Firefighter Classification: FFT2
7. Rate: GS
8. Date and Time: 07-10-2008 1800-2200 4.00
9. Total Hours: 56.00
10. Gross Amount: 07/10-07/16
11. Inclusive Dates: 07/10-07/16
12. Time Officer's Signature: [Signature]
13. Date Signed: 7-16-2008
21. SHOW "H" FOR HAZARD PAY AND "E" PLUS % FOR ENVIRONMENTAL DIFFERENTIAL
22. Commodity Record
a. Date: 07/16/XX
b. Item: Toiletries
c. Amount: 11.00
23. Remarks: 7/12 injured at 1015
24. ALSO Check Number and Stamp
25. Employee Signature: [Signature]
26. Issue Officer (Signature): [Signature]

EXHIBIT 21
EMERGENCY FIREFIGHTER TIME REPORT (OF-288) SHOWING COP
FOR A CASUAL

EMERGENCY FIREFIGHTER TIME REPORT Form 7111. Includes sections for personal information, fire location identification, time report table, and compensation details. Handwritten entries include names Jose Valdez and Maria Valdez, location Warm Lake, and dates 08/01-08/04 and 4-Aug.

OPTIONAL FORM 288 (Rev. 3/93)
USDARV'S 11
50288-102

ORIGINAL - PAYROLL COPY

EXHIBIT 22
SAMPLE INCIDENT INJURY CASE FILE ENVELOPE

NAME OF CLAIMANT <i>Müller, Amy</i>	DATE OF INJURY OR ILLNESS <i>7/12/xxxx</i>	APMC []	OWCP [✓]	FIRST AID ONLY []
INCIDENT/COMPLEX NAME <i>Warm Lake</i>	INCIDENT NUMBER <i>ID-B0D-005161</i>	UNIT LOG NUMBER M-		

CHECK LIST FOR CASE FILES

(Indicate Whether Completed)	YES (Date)	NO
*CA-1 – Report of Injury	<i>7/12/xx</i>	
*CA-2 – Report of Illness		
CA -16 Request for Examination and/or Treatment	<i>7/12/xx</i>	
FS-6100-16 – Agency Provided Medical Care Authorization and Medical Report		
CA - 17 – Duty Status Report		
HCFA – 1500 – Health Insurance Claim Form	<i>7/12/xx</i>	
Follow-up Action Needed		

CLAIMANT ASSIGNED TO:

(Crew Name or OH Section)

CLAIMANT'S HOME UNIT: *BLM Boise District Office*

(Agency)
3924 Development Ave.
 (Address)

Boise, ID 83705
 (City, State and Zip Code)
(208) 555-1212
 (Telephone No. with Area Code)

SUPERVISOR ON INCIDENT: *Laine Schwarberg*

SUPERVISOR'S HOME UNIT: *BLM Boise District Office*

(Agency)

3924 Development Ave.
 (Address)

Boise, ID 83705
 (City, State and Zip Code)
(208) 555-1212
 (Telephone No. with Area Code)

*NOTE: **ORIGINAL** form must go to employee's home (or hiring) unit.

Follow-up Needs/Comments: *Lost time injury; stitches need to be removed by personal physician.*

COMPENSATION FOR INJURY SPECIALIST/UNIT LEADER NAME <i>Siegel/Batey</i>	HOME UNIT TELEPHONE NUMBER (W/AREA CODE) <i>(208) 555-1212</i>	FINANCE/ADMIN SECTION CHIEF INITIALS <i>sg</i>
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