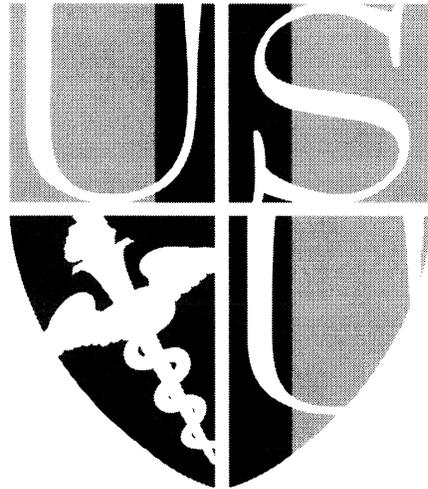


**USUHS
INSTRUCTION
6002**





UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES



SUBJECT: USUHS Occupational Health and Safety Program, Including Work-Related Injuries, Illnesses, and Medical Emergencies Involving University Employees

Instruction 6002

JAN 12 2000

(EHS)

ABSTRACT

This Instruction implements Federal guidelines for an Occupational Health and Safety Program within the Uniformed Services University of the Health Sciences (USUHS), including procedures for reporting injuries, illnesses, and medical emergencies experienced by USUHS employees within the scope of their employment at the USUHS. It gives the responsibility for the establishment, implementation, and operation of the USUHS Occupational Health and Safety Program to the Environmental Health and Occupational Safety (EHS) Department. This Program includes physical examinations (as needed) and surveillance programs for various environmental concerns, such as asbestos, hazardous chemicals, and radiation exposures.

A. Reissuance and Purpose. This Instruction reissues USUHS Instruction 6002^a and implements DoD Instruction 6055.1^b, DoD Instruction 6055.5^c, DoD Manual 6055.5-M^d, DoD Directive 1000.3^e, FPM Chapter 810^f, Executive Order 11491^g, Title 5, USC, Section 8101^h, USUHS Instruction 6401ⁱ, and USUHS Instruction 6402^j. This Instruction also assigns responsibilities for implementing an Occupational Health and Safety Program within the USUHS, including procedures for reporting injuries, illnesses, and medical emergencies experienced by USUHS employees within their scope of employment at the USUHS.

B. References. *See Enclosure 1.*

C. Applicability. This Instruction applies to all USUHS personnel.

D. Policy.

It is the USUHS policy that occupational health and safety programs will be established and maintained as an element of the overall DoD Mishap Prevention Program as prescribed in FPM Chapter 810^f and the Occupational Health Program prescribed in DoD Instruction 6055.5^c and DoD Manual 6055.5-M^d. The program will include baseline and periodic physical examinations of selected personnel

in certain occupations. Employees will receive prompt medical attention and assistance in claiming just compensation for injuries or illnesses incurred in the performance of duties.

E. Definitions. *See Enclosure 2.*

F. Responsibility.

The Environmental Health and Occupational Safety Department shall be responsible for establishing, implementing, and operating the USUHS Occupational Health and Safety Program.

G. USUHS Occupational Safety and Health Standards and Guidelines.

USUHS Occupational Safety and Health (OSH) standards as specified below will be applicable:

1. OSH standards, including those standards promulgated by the Occupational Safety and Health Administration (OSHA) pursuant to Title 29, USC, Sections 651-678^k, with minimal minor adaptation to conform to USUHS administrative practices. The USUHS may, as an option, include more current editions of national consensus standards referenced in the OSHA standards;

2. Alternate criteria authorized for the USUHS by DoD;

3. USUHS Instruction 6402-M^l;

4. USUHS Instruction 6053-M^m;

5. USUHS Instruction 6401ⁱ; and

6. Applicable National Naval Medical Center (NNMC) safety instructions and record keeping procedures.

H. Pre-Employment and Periodic Physical Examinations.

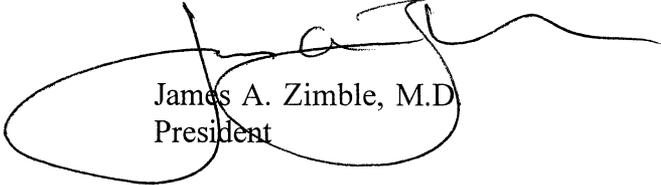
In order to monitor employees for potential exposure to job-related hazards, baseline and/or periodic physical examinations may be required. Specifications and guidelines for physical examinations are set forth in DoD Manual 6055.5-M^d.

I. USUHS Workplace Surveys and Inspections.

All workplaces and operations will be inspected annually by EHS. High-hazard areas will be inspected more frequently based upon assessment of the exposure and potential severity of injuries, occupational illness, or damage to USUHS property. A report of deficiencies and violations, together with recommendations for corrective actions, will be provided to applicable activities. Copies will be provided to the Vice President, Teaching and Research Support (TRS) and others as deemed appropriate. Follow-up inspections will be conducted to ensure compliance with recommendations for corrective action.

J. Work-Related Injuries, Illnesses and Medical Emergencies. *See Enclosure 3.*

K. Medical Emergencies at the USUHS
During Routine Duty Hours and Non-
Regular Duty Hours. *See Enclosure 4.*



James A. Zimble, M.D.
President

Enclosures:

1. References
2. Definitions
3. Guidelines for Work-Related Injuries or Illnesses
4. Guidelines for Medical Emergencies at the USUHS During Routine Duty Hours and Non-Regular Duty Hours

REFERENCES

- (a) USUHS Instruction 6002, "USUHS Occupational Safety and Health Program, Including Work Related Injuries or Illness," dated September 10, 1990 (hereby cancelled)
- (b) DoD Instruction 6055.1, "Department of Defense Occupational Safety and Health (OSH) Program," dated August 19, 1998
- (c) DoD Instruction 6055.5, "Industrial Hygiene and Occupational Health," dated January 10, 1989
- (d) DoD Manual 6055.5-M, "Occupational Health Surveillance Manual," dated July 1982
- (e) DoD Directive 1000.3, "Safety and Occupational Health Policy for the Department of Defense," dated March 29, 1979
- (f) Federal Personnel Manual Chapter 810, "Injury Compensation"
- (g) Executive Order 11491, "Labor-Management Relations in Federal Service"
- (h) Title 5, United States Code, Section 8101, "Federal Employees' Compensation Act"
- (i) USUHS Instruction 6401, "Biohazards and Dangerous Materials Guide," dated May 15, 1987
- (j) USUHS Instruction 6402, "Compliance with USUHS Radiation Safety Guide," dated March 29, 1990
- (k) Title 29, United States Code, Sections 651-678, "Occupational Safety and Health"
- (l) USUHS Instruction 6402-M, "Radiation Safety Guide," dated July 1994
- (m) USUHS Instruction 6053-M, "USUHS Safety Manual," dated March 15, 1988

DEFINITIONS

1. Traumatic Injury - A wound or other condition of the body caused by external force, including physical stress and/or strain, which must be identified by the time and place of occurrence, member or function of body affected, and be caused by a specific event or incident within a single day or workshift.

2. Occupational Disease/Illness - A health condition produced by an infection; continued or repeated physical stress or

strain; exposure to toxins, radiation, poisons, fumes, etc.; or repeated exposure to work environment conditions over a long period of time.

3. Non Work-Related Emergency - An event which occurs suddenly while on USUHS duty that can lead to loss of life or significant impairment of normal physiologic function (i.e., stroke, heart attack, or seizure).

GUIDELINES FOR WORK-RELATED INJURIES OR ILLNESSES

A. Routing Procedures for Responding to Work-Related Illnesses. See *Attachment 1*.

1. If an employee or visitor sustains an emergency work-related injury or illness during his/her working hours, the employee must immediately call the local Emergency System dispatcher at telephone number 777 and follow the procedures as specified in *Enclosure 4*.

2. If a civilian or a military employee sustains a work-related injury or illness during his/her working hours, the employee must immediately:

- a. Notify his/her supervisor;
- b. Have his/her supervisor

prepare an OPNAV 5100/9, see *Attachment 2*, if he/she is going to be seen in the Emergency Department at the NNMC for treatment. Military employees may choose to report to the University Health Clinic (UHC). Guidelines for employees of the Henry M. Jackson Foundation for the Advancement of Military Medicine (HJF) who work at the USUHS are outlined in this *Enclosure*. Authorization, documentation, and reporting requirements for supervisors of HJF employees are determined by HJF:

(1) civilian employees may elect to report to a medical facility other than NNMC for evaluation and treatment. If a medical facility other than NNMC is utilized, the employee will inform the health-care provider that the injury or illness is work-related and request that a copy of the physician's report be

forwarded to the Civilian Human Resources (CHR) Directorate at the USUHS, or

(2) HJF civilian employees must report to Suburban Hospital, for non-emergency work-related injuries or illnesses;

NOTE: A list of all Compensation Act (CA) Forms is provided in *Attachment 3*.

c. For USUHS civilian employees, the supervisor must check item **6A** of Form CA-16, see *Attachment 4*, if he/she has personal knowledge of the injury, as this provides authority for all necessary treatment with the exception of elective surgery. All necessary forms and guidance for their use may be obtained from CHR;

d. For USUHS civilian employees, the attending physician must furnish an immediate medical report to CHR for all cases reported to the Occupational Workers' Compensation Program;

e. For USUHS civilian employees, the supervisor will notify CHR of all sustained injuries and forward all CA forms as soon as completed to that office; and

f. For USUHS civilian employees, the supervisor will notify CHR immediately upon the return of the injured employee to work. The supervisor will submit for the USUHS civilian employees the appropriate CA Form (Form CA-1, see *Attachment 5* or Form CA-2, see *Attachment 6*) to CHR within two working days.

B. Responsibilities.

1. The University Health Clinic shall:
a. Be notified during Routine Duty Hours (0730-1600) that an emergency exists;

b. Provide a response team to provide medical assistance to the employee until ambulance personnel arrive on the scene; and

c. Notify EHS upon learning of a work-related injury or illness to any military or civilian employee.

2. Supervisors shall:

a. Provide safe, healthy working conditions (areas and equipment), and ensure that all employees understand their responsibilities for accident prevention and the procedures to follow in reporting accidents immediately upon occurrence;

b. Prepare an OPNAV 5100/9 for all USUHS civilian and military employees to accompany the patient if he/she is going for treatment to the NNMC Emergency Department. Dispensary Permits are available from EHS;

c. Prepare a Form CA-16 for USUHS civilian employees. Immediately authorize examination and appropriate medical treatment, and issue the Form CA-16 to the employee referred to the NNMC Emergency Department or any duly qualified physician or hospital of the employee's choice, during routine hours (0730 - 1600). To complete Form CA-16 do the following:

(1) check item **6A and 6B** of Form CA-16 when there is no doubt that the civilian employee's disability was caused by an injury while in the performance of duty, and

(2) give verbal authorization for emergency treatment; however, a Form CA-16 will be issued within 48 hours to the facility or clinic chosen by the employee if treatment is not given by NNMC;

d. Have USUHS civilian employees complete items **1 through 16** of Form CA-1 or items **1 through 21** of Form CA-2, as appropriate. Have any witness complete items **17 through 20** of Form CA-1. The supervisor will complete items **21 through 47** and the Receipt of Notice of Injury of Form CA-1 or items **22 through 50** and the Receipt of Notice of Disease of Illness of Form CA-2. The employee must forward Form CA-1 to the CHR within two working days;

e. For HJF civilian employees, immediately authorize examination and medical treatment. Contact CHR to notify them of the injury to one of the HJF employees and to obtain appropriate forms for documenting the injury or illness; and

f. Complete USUHS Form 6012, see *Attachment 7*, and forward to EHS within two working days. Copies of this form may be obtained from EHS.

3. Employees shall:

a. Observe all safety instructions, regulations and procedures, and immediately report all job-connected injuries or illnesses to their supervisor;

b. Report for medical treatment as prescribed by established procedures or as directed by their supervisors; and

c. Report to their supervisors immediately upon sustaining a traumatic, disabling injury in the performance of duty

before obtaining medical care, except in a life-threatening emergency. USUHS civilian employees will file written notice on Form CA-1 within two working days following the injury; or in the case of an occupational disease, file Form CA-2. A compensation claim for disability must be made within 30 days after sustaining the disease/injury in the performance of duty (forms will not be completed for military personnel). For additional time specified by the compensation law, contact CHR.

Exception: HJF employees must comply with time reporting requirements as stated in HJF Regulations.

4. Civilian Human Resources shall:
 - a. Notify EHS upon learning of an injury to any civilian employee;
 - b. Inform USUHS civilian employees of reporting procedures required in administering Title 5, USC, Section 8101^h and furnish employees with the necessary forms for reporting an injury;
 - c. Counsel injured USUHS civilian employees concerning their benefits and advise them of the specific procedures for submitting claims;

- d. Inform USUHS civilian employees of their right to elect continuation of regular pay or to use annual or sick leave, if the injury is disabling, by completing Form CA-1 within 30 calendar days of the date of injury; and

- e. Inform USUHS civilian employees whether continuation of pay will be disputed, and if so, whether it will be terminated, and the basis of this action.

5. Environmental Health and Occupation Safety shall:

- a. Establish and maintain a log of occupational injuries and illnesses to provide a quick and current overview of workplace safety and health throughout the USUHS;

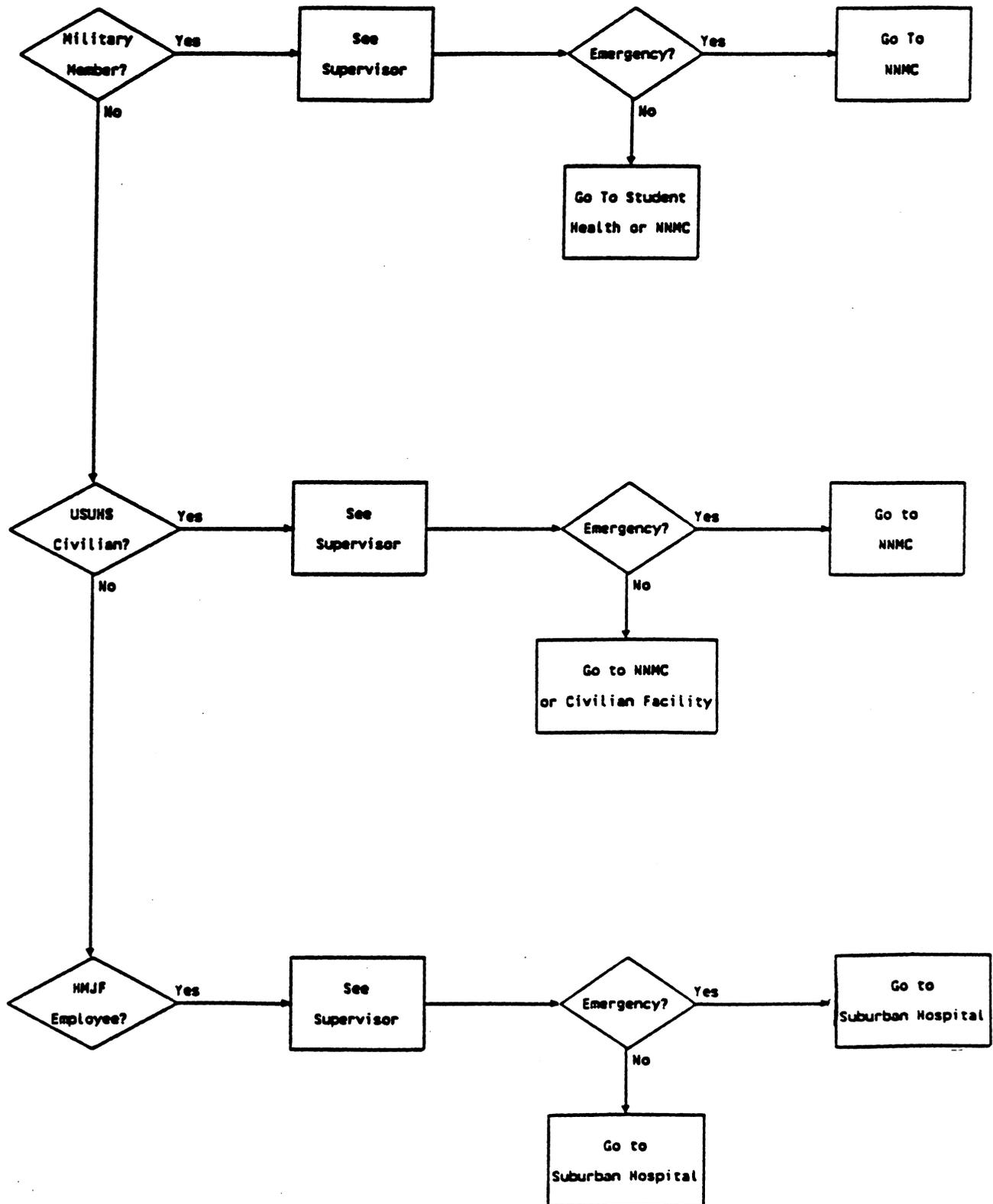
- b. Upon receipt of a completed USUHS Form 6012, analyze the data to identify unsafe and unhealthful working conditions; and

- c. Make recommendations, if needed, for correcting the cause leading to any injury or illness.

Attachments:

1. Routing Procedure for Work-Related Illnesses
2. OPNAV 5100/9
3. List of Compensation Act (CA) Forms
4. Form CA-16
5. Form CA-1
6. Form CA-2
7. USUHS Form 6012

Routing Procedure for Work-Related Illnesses



Dispensary Permit

CASE NUMBER

PRIVACY ACT STATEMENT BELOW

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		DEGREE OF INJURY <input type="checkbox"/> FIRST AID <input type="checkbox"/> MEDICAL TREATMENT <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"/> SENT HOME BY DISPENSARY
<input type="checkbox"/> REFERRED TO PRIVATE PHYSICIAN/HOSPITAL		<input type="checkbox"/> OTHER (Explain)		
REMARKS/DIAGNOSIS				
MEDICAL OFFICER'S SIGNATURE		INITIAL TREATMENT DETERMINATION <input type="checkbox"/> DISCHARGED, TREATMENT COMPLETED <input type="checkbox"/> RE-TREATMENT REQUIRED		

OPNAV 5100/9 (Rev 10-92)

S/N 0107-LF-015-8300

PRIVACY ACT STATEMENT

Authority: SECNAVINST 5100.10E and OPNAVINST 5100.23C

Principal Purpose: To ensure prompt investigation of occupational injuries, and to initiate any necessary immediate corrective action.

Routine Use: Routinely used by the activity Occupational Safety and Health Office to perform official duties in the investigation of mishaps which may have caused occupational injury or illness.

Disclosure: Voluntary. Treatment will be provided without regard to employee's willingness to divulge all or part of the requested information.

COMPENSATION ACT (CA) FORMS ***

FORM	TITLE	WHEN COMPLETED	COMPLETED BY
CA-1 Front	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.	Within 2 days after an injury, or as soon as possible, but not later than 30 days.	Employee (or someone acting in employee's behalf) completes 1-16. Supervisor completes "Receipt of Notice of Injury" and gives to employee.
CA-1 Back	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.	Upon receiving CA-1 Form which has been completed by the injured employee.	Immediate supervisor. Forwarded to Personnel Office within 2 working days following receipt of form from employee.
CA-2 Front	Federal Employee's Notice of Occupational Disease and Claim for Compensation.	Within 30 days after employee has sustained an occupational disease.	Employee (or someone acting in employee's behalf). Supervisor completes "Receipt of Notice of Injury" and returns to employee.
CA-2 Back	Federal Employee's Notice of Occupational Disease and Claim for Compensation.	Upon receiving notification from employee.	Immediate supervisor forwards to Personnel Office within 10 working days following receipt of form from employee.
CA-3	Report of Termination of Disability and/or Payment.	Immediately after employee returns to work or disability ceases.	Immediate supervisor.
CA-4	Claim for Compensation on Account of Occupational Disease.	Accompanied by a medical report, showing continued disability beyond 10 days (may be filed any time after the date pay stops).	Employee for employee position, supervisor for appropriate items on attached Ca-20.
CA-5	Claim for Compensation by Widow, Widower and/or Children.	Form will be sent from OWCP to supervisor as soon as notification of death is received.	Dependents of deceased employee. Supervisor should assist with the preparation of forms.
CA-6	Official Supervisor's Report of Employee's Death.	Promptly after death of employee and after notifying OWCP.	Supervisor.

	TITLE	WHEN COMPLETED	COMPLETED BY
CA-7	Claim for Compensation on Account of Traumatic Injury.	Where disability continues, employee and supervisor must complete and file not more than 5 working days following 45-day period.	Employee and supervisor and accompanied by a medical report showing continued disability beyond end of 45-day period.
CA-8	Claim for Continuance of Compensation on Account of Disability.	To claim additional periods of time after CA-4 or CA-7 is submitted. When temporary total disability continues, claim is submitted every 2 weeks until otherwise notified by OWCP.	Employee completes and signs form. Supervisor completes appropriate section of form.
CA-10	What a Federal Employee Should do When Injured on the Job.	Personnel Office distributes for posting on bulletin boards.	Personnel Office.
CA-16	Request for Examination and/or Treatment.	Immediately after being notified of an employee injury.	Immediate supervisor and forward with injured employee to a duly qualified physician or hospital of the employee's choice. In emergencies, CA-16 will be submitted immediately thereafter.
CA-17	Duty Status Report.	At intervals as often as required by the agency.	Employee's physician, who will forward the original to the Personnel Office and a copy to the OWCP district office.
CA-20	Attending Physician's Report.	Use when narrative medical report on CA-16 was not sent to OWCP in past 10 calendar days.	Immediate supervisor (Items 1-4 and OWCP address on back of form). Attending physician completes and forwards original directly to OWCP and forwards a copy to the Personnel Office.

*** ONE COPY OF EACH FORM IS REQUIRED

**Authorization for Examination
And/Or Treatment**

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

**Enclosure 3
Attachment 4**



The following request for information is authorized by law (5 USC 8101 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 Cir. No. A-108.

OMB No.: 1215-0103
Expires: 10-31-94

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)	3. Date of Injury (mo. day, yr.)	4. Occupation
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5. Description of Injury or Disease:

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 35 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. Furnish office and/or hospital treatment as medically necessary for the effects of this 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:
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9. Name and Title of Authorizing Official: (Type or print clearly)

10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
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12. Send one copy of your report: (Fill in remainder of address)	13. Name and Address of Employee's Place of Employment:
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U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

Department of Agency

Bureau or Office

Local Address (including Zip Code)

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. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

**SELECTION OF
PHYSICIAN**

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/ hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

**PERIOD OF
AUTHORIZATION**

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

**FEDERAL MEDICAL
FACILITIES**

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

**DEFINITION
OF INJURY**

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

**DEFINITION OF
PHYSICIAN**

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

**FORM
COMPLETION**

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

**ADDITIONAL
INFORMATION**

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

INFORMATION FOR PHYSICIAN

**YOUR
AUTHORIZATION**

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

**USE OF CONSULTANTS
AND HOSPITALS**

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

**RELEASE OF
RECORDS**

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

**BILLING FOR
SERVICES**

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

**TAX IDENTIFICATION
NUMBER**

- The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

**ADDITIONAL
INFORMATION**

- Contact the OWCP shown in Item 12 of Part A.

*U.S. Government Printing Office: 1993 — 342-027/80440

Please Remove These Instructions Before Submitting Your Report.

**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.

Employee Data					
1. Name of employee (Last, First, Middle)					2. Social Security Number
3. Date of birth Mo. Day Yr. 	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		5. Home telephone ()	6. Grade as of date of injury Level Step	
7. Employee's home mailing address (Include city, state, and ZIP code)					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 Mo. Day Yr. 	Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr. 	12. Employee's occupation
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13. 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

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 _____

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.

Witness Statement

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

**Enclosure 3
Attachment 5**

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

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. a.m. p.m. 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

Enclosure 3
Attachment 5

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

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.)

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.

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

Claim Information	
9. Employee's occupation	a. Occupation code
10. Location (address) where you worked when disease or illness occurred (Include city, state, and zip code)	11. Date you first became aware of disease or illness Mo. Day Yr.
12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr. 	13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness	GWCP 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

16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

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 _____ Date _____

Have your supervisor complete the receipt attached to this form and return it to you for your 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 felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

**Enclosure 3
Attachment 6**

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
	OSHA Site Code
Zip Code	

20. Employee's duty station (Street address and zip code)	Zip Code
---	----------

21. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	22. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input 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 Mo. Day Yr. _____
	25. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

26. Date employee first reported condition to supervisor Mo. Day Yr. _____	27. Date and hour employee stopped work Mo. Day Yr. _____ Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
--	--	--

28. Date and hour employee's pay stopped Mo. Day Yr. _____ Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr. _____
---	--

30. Date returned to work Mo. Day Yr. _____ Time : <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
--	--

31. If employee has returned to work and work assignment has changed, describe new duties

32. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," go to item 34.	33. Name and address of third party (Include city, state, and zip code)
--	---

Signature of Supervisor

34. 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)

Signature of Supervisor Date

Supervisor's Title Office phone

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

- (1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.
- (2) Payment of compensation for total or partial wage loss.
- (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.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

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. 93-570, 5 U.S.C. 552a), 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 may be used by other agencies or persons in matters relating directly or indirectly to the matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or complied with the provisions of 20 CFR 10.

(4) 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 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).

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Instructions for Completing Form CA-2

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. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or illness completed by the the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

- a) A detailed history of the disease or illness from the date it started.
- b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.
- c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.
- d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)
- e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

- a) Dates of examination or treatment.
- b) History given to the physician by the employee.
- c) Detailed description of the physician's findings.
- d) Results of x-rays, laboratory tests, etc.
- e) Diagnosis.
- f) Clinical course of treatment.
- g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible 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 must be sent to OWCP within ten working days after it is received. In a separate, narrative statement attached to the form, the supervisor must:

- a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.
- b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.
- c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.
- d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)
- e) Review and comment on the accuracy of the employee's statement requested above.

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

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

14. Nature of the disease or illness

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. 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).

20. Employee's duty station, street address and zip code

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

23. 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.

24. First date medical care received

The date of the first visit to the physician listed in item 23.

32. Was the 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 disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

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, Record Keeping 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.

SUPERVISOR'S REPORT OF ACCIDENT
USUHS Form 6012 (EHS) (Rev 7/85)

TO: EHS

FROM: (Supervisor and Department)

VIA: (If Applicable)

1. Date of Accident	Time	Location
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2. Name of Injured	Age	Job Title
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Years Experience At Present Job	Nature of Injury
------------------------------------	------------------

3. Property Damage (If Applicable)

4. Witness/es

5. Description of Accident - Detailed Description of Accident by Immediate Supervisor
(After Interview of Injured and Witnesses, Examination of Evidence and Location,
Etc.)

CA 1&2 Completed Yes No

Probable Loss Time Yes No

6. Immediate Unsafe Factors - What Were the Immediate Unsafe Factors Which Caused This Accident? (Please Check Applicable block/s)

- Unsafe mechanical/physical/environmental condition at time of accident
- Unsafe act by injured and/or others contributing to the accident
- Personal factor (Improper attitude, lack of knowledge or skill, slow reaction, fatigue, etc.)
- Personal protective equipment required? _____ (specify)
- Was injured using required protective equipment? Yes No (explain if "no")
- Others. (Explain. Attach extra sheet if necessary)

7. Corrective Action - What Has Been Done to Prevent a Recurrence of This Type of Accident? (It Will Happen Again If the Unsafe Act is Repeated, or If the Unsafe Condition is Allowed to Exist. Also State What Remains to be Done, Action Others Should Take, Etc.)

Report Completed By (Supervisor's Signature)	Date
This report has been reviewed and the corrective action above has been taken. This corrective action will be applied wherever appropriate throughout the department.	
Signature (Department Chairperson)	Date
EHS Review: Signature	Date

**GUIDELINES FOR MEDICAL EMERGENCIES AT THE USUHS
DURING ROUTINE DUTY HOURS AND NON-REGULAR
DUTY HOURS**

A. Purpose.

These guidelines establish responsibility for the provision of emergency medical care on the USUHS campus and provide specific information for obtaining emergency care for all USUHS employees, both civilian and military.

B. Definition.

A medical emergency is any event occurring to one or more individuals that occurs suddenly and can lead to loss of life or significant impairment of normal physiologic function.

C. Background.

The UHC is the only facility on the USUHS Campus involved in active patient care. However, it is not manned on a 24-hour basis and is not designed to provide emergency medical treatment (i.e., suturing, x-rays, etc.).

D. Policy.

A uniform and coordinated approach to medical emergencies on the USUHS campus will provide an optimum level of care to the individual involved.

E. Responsibilities.

The Emergency Department, NNMC shall be the initial provider and coordinator for emergency care on the USUHS Campus during both routine duty hours and non-regular duty hours.

F. Procedures.

1. If an employee, either military or civilian, experiences a medical emergency he/she shall call telephone number 777, which will access the local 777 Emergency System dispatcher.

2. When calling the Emergency (777) System Dispatcher follow these easy steps:

a. **STAY CALM;**

b. Provide the dispatcher with the exact location of the emergency, including the building, floor, and room number; and

c. Give the dispatcher your name and the telephone number where you can be reached. They may need to call you back if the ambulance crew has difficulty locating the scene of the medical emergency.

3. Call the USUHS Security at telephone extension 295-3038 to tell them of the location where the incident has occurred and that an ambulance has been summoned to the USUHS.

4. Call UHC during Routine Duty Hours (0730-1600) at telephone extension 295-3630 to inform them that an emergency exists and that an ambulance has been summoned to the USUHS.