## **U.S. Department of Labor** Employment Standards Administration

Office of Workers' Compensation Programs



SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?  Yes	SECTION 1		E	MPLOYEE PO	ORTION				
b. Mailing Address (Including City State, ZIP Code)    C. OWCP File Number	a. Name of Er	nployee La	st	First		Middle			
d. Date of Injury   E-Mail Address (Optional)   SECTION 2   Compensation is claimed for:   Inclusive Date Range   From	h Mailing Add	Irona (Ingludina Ci	ty State 7/D Code				· ·		
E-Mail Address (Optional)  SECTION 2 Compensation is claimed for: From From From From From From From From	b. Mailing Aud	iless (including Cil	ly State, ZIP Code)				C. OVVCI	i ile ivaiiii	bei
E-Mail Address (Optional)  SECTION 2 Compensation is claimed for: From:			_		d. Date	e of Injury	e. Social S	Security N	lumber
SECTION 2 Compensation is claimed for:	F-Mail Addres	s (Ontional)			Month	Day Year			
a. Leave without pay   Intermittent?   Can be provided and the second of			alaimad fari				f. Telepho	ne No./F	AX No.
a. Leave without pay	SECTION 2	Compensation is t	Inclusive D	a <u>te</u> Range	1.1		(	) –	
b.   Leave buy back     Yes   No   Go to Section 3, and Complete Form CA-7b   Yes   No   Go to Section 3, and Complete Form CA-7b   Yes   No   Go to Section 3   Section 3   Section 3   Section 3   Section 3   Section 3   Section 4   Yes   Sheet   Yes   S			FIOIII	10				)	
C. Other wage loss: specify type.  Such as adwingrade. loss of injet differential, etc.  Type:	_	· ·						loto F	
such as döwngrade, loss of night differential, etc.    Schedule Award (Go to Section 4)   Time Analysis Sheet	_	•	type		= =			ompiete F	OIIII CA-7D
d. Schedule Award (Go to Section 4)  SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commission, volunteer, etc.)  Name and Address of Business:    No	such a	s downgrade, loss	of _		_				
SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2?  (Include salaried, self-employed, commission, volunteer, etc.)  Name and Address of Business:  Name Address Section 4 Dates Worked:  SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?  Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"  Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?  Yes Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)  List your dependents (including spouse):  List your dependents (including spouse):  Social Security # Date of Birth  Yes No  If Yes, support payments are made to:  Name  Section 6 a. Was/Will there be a claim made against a 3rd party?  Yes No  Betwere support payments ordered by a court?  Yes No  Have you ever applied for or received disability benefits from the Department of Veterans Affairs?  Yes Claim Number  Full Address of VA Office Where Claim Filed  No  Letter or received payment under any Federal Retirement or Disability law?  Yes Claim Number  Date Annuity Began  Amount of Monthly Payment  Retirement System (CSRS, FERS, SSA, Other)  CSRS FERS SSA Other  SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.  Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly cacepts compensation or 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							CA-1a,		
Yes		·	<u> </u>	during the peri					
Name   Address   City   State   ZIP Code	OLOTION 3					Occilon 2:			
Dates Worked: Type of Work:	Yes	Name and Addre	ss of Business:						
Dates Worked: Type of Work:		Name		Address			City	State	ZIP Code
Section 4   Is this the first CA-7 claim for compensation you have filed for this injury?	Go to			71001000			Oity	Olalo	211 0000
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SECTION 5 List your dependents (including spouse):  Name  Social Security # Date of Birth Relationship Yes No		filed with U.S. Civ	vil Service Retirement, a	nother federal	retirement or disa	ability law, or w	vith the Depa	artment of	Veterans
Name Social Security # Date of Birth Relationship Yes No    J   J   For dependents not   Iving with you, complete   items a and b below.		•	-	or a new SF-1	199A to reflect c	hange(s)	☐ No -	Complete	Section 7
		List your depend	,	ritu# Data	a of Dimble Dol				
a. Are you making support payments for a dependent shown above?	ivame		Social Sect	inty # Date	e or Birth - Rei / /	iationsnip y F			
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Employee's Signature Date (Mo., dav. vear)	compensation administrative	as provided by the remedies as well	e FECA, or who knowing as felony criminal prose	ly accepts con cution and ma	npensation to wh y, under appropri	ich that persor iate criminal pr	n is not entitl rovisions, be	ed is subj punished	ect to civil or
	Employee's Si	gnature				Date ( <i>Mo., dav</i>	v. vear)		

## Employing Agency Portion For first CA-7 claim sent, complete sections 8 through 15. For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate a	is of	Additional Pay			•		Addi			
Date of Injury: Base Pay		Туре	Туре		_		Туре			
Date:// \$	per	\$ per	_	_ per _		\$		pe	r	
Grade: Step:										
Date Employee Stopped Work:		Туре	Туре				Туре			
Date:/	per	\$ per	_	_ per _		\$		pe	r	
Grade: Step:										
Additional pay types include, but are not li	mited to: Nigh	t Differential (ND), Sund	lay Premium	(SP), Ho	liday P	remiu	m (H	P), S	ubsis	ten
SUB), Quarter (QTR), etc. (List each sepa	arately)									
<b>SECTION 9</b> a. Does employee work a fixed 40-hour p	er week sched	dule? vaa 🗆 Na 🗀	1							
			-	C						
<ol> <li>If Yes, circle scheduled days:</li> <li>If No, show scheduled hours for the to</li> </ol>				S the day t	hat wor	k etor	had			
FOR EXAMPLE ONL		Defide in Which work 3to	ppcu. Onoic	inc day i	ilat woi	K Stop	opcu.			
	T W TH	FS		-	в Гм	Т	w	TH	F	S
WEEK 1				F	<del>-   '''</del>			•	•	_
From <u>5/14</u> to <u>5/20</u> 8 6	$\begin{array}{c c} 4 & 6 & 6 \end{array}$	From	to							
WEEK 8	6 6	4								
From <u>5/21</u> to <u>5/27</u>		From	to							
. Did employee work in position for 11 mc	onths prior to in	njury? Tyes	No							
No, would position have afforded employ				es 🗌	Nο					
<b>ECTION 10</b> On date pay stopped, was			<u> </u>							
	———	oned m. ⊐r— c. Optional Use Ir	seuranco2 [		1 <sub>V00</sub>	Class	_			
i nealin benellis linner					1 1 45	U.IASS	~			
the FEHBP? No Yes	Code						<u> </u>	(D-Z	only	/)
the FEHBP?	Code	d. A Retirement S		No C	Yes	Plan		•	-	•
Health Benefits under the FEHBP?		d. A Retirement S		□ No □	] Yes	Plan S <i>peci</i>	fy CS	RS, I	-	•
the FEHBP? No Yes  Basic Life Insurance? No Yes  ECTION 11 Continuation of Pay (COP)	Received (Sh	d. A Retirement S		No C	Yes	Plan S <i>peci</i> mplet	<i>fy CS</i> e Tin	RS, I	FERS	•
the FEHBP? No Yes  Basic Life Insurance? No Yes  BECTION 11 Continuation of Pay (COP)	Received (Sh	d. A Retirement S	System? [	No C	Yes (S S — Co alysis S	Plan S <i>peci</i> mplet	<i>fy CS</i> e Tin	RS, I	FERS	•
the FEHBP? No Yes  Basic Life Insurance? No Yes  BECTION 11 Continuation of Pay (COP)	Received (Sh	d. A Retirement S	System? [	No C	Yes (S S — Co alysis S	Plan S <i>peci</i> mplet	<i>fy CS</i> e Tin	RS, I	FERS	•
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Fax No. (\_\_\_\_\_ E-Mail Address\_\_\_\_\_

Telephone No. ( )