Claim for Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee Last First Middle

OMB No. 1215-0103
Expires: 08/31/2005

b. Mailing Address (*Including City State, ZIP Code*)

c. OWCP File Number

d. Date of Injury Month Day Year

e. Social Security Number

E-Mail Address *(Optional)*

f. Telephone No./FAX No.
( ) –
( )

SECTION 2 Compensation is claimed for:

	Inclusive Date Range From	To	Intermittent?	
a. ☐ Leave without pay			☐ Yes ☐ No	*Go to Section 3*
b. ☐ Leave buy back			☐ Yes ☐ No	*Go to Section 3, and Complete Form CA-7b*
c. ☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type:			☐ Yes ☐ No	*Go to Section 3*
d. ☐ Schedule Award (*Go to Section 4)*			If intermittent, complete Form CA-7a, Time Analysis Sheet	

SECTION 3 Have you worked outside your federal job during the period(s) claimed in Section 2? (*Include salaried, self-employed, commission, volunteer, etc.)*

☐ Yes Name and Address of Business:

☐ No *Go to section 4*

Name Address City State ZIP Code

Dates Worked: Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No 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)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (*including spouse*):

Name	Social Security #	Date of Birth	Relationship	Living with you? Yes	No
		/ /		☐	☐
		/ /		☐	☐
		/ /		☐	☐

For dependents not living with you, complete items a and b below.

a. Are you making support payments for a dependent shown above? ☐ Yes ☐ No If Yes, support payments are made to:

Name Address City State ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

☐ Yes ☐ No	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment

c. Have you applied for or received payment under any Federal Retirement or Disability law?

☐ Yes ☐ No	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 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. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature _____ Date (*Mo., day, year*) _____

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 as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury: Base Pay	Type _____	Type _____	Type _____
Date: ___/___/___ $_____ per _____	$ _____ per _____	$ _____ per _____	$ _____ per _____
Grade:_____ Step: _____			
Date Employee Stopped Work:	Type _____	Type _____	Type _____
Date: ___/___/___ $_____ per _____	$ _____ per _____	$ _____ per _____	$ _____ per _____
Grade:_____ Step: _____			

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SECTION 9

a. Does employee work a fixed 40-hour per week schedule? Yes ☐ No ☐

1. If Yes, circle scheduled days: S M T W TH F S
2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

	S	M	T	W	TH	F	S
WEEK 1 From 5/14 to 5/20		8	4	6	(6)		
WEEK From 5/21 to 5/27		8		6	6		4

	S	M	T	W	TH	F	S
From _____ to _____							
From _____ to _____							

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No

If No, would position have afforded employment for 11 months but for the injury? ☐ Yes ☐ No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? ☐ No ☐ Yes Code ☐☐☐

b. Basic Life Insurance? ☐ No ☐ Yes

c. Optional Use Insurance? ☐ No ☐ Yes Class _____ *(D-Z only)*

d. A Retirement System? ☐ No ☐ Yes Plan _____ *(Specify CSRS, FERS, Other)*

SECTION 11 Continuation of Pay (COP) Received (*Show inclusive dates*):

From ___/___/___ To ___/___/___

Intermittent? ☐ Yes — Complete Time Analysis Sheet, Form CA-7a ☐ No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

		Intermittent?	
Sick Leave From	___/___/___ To ___/___/___	☐ Yes	☐ No
Annual Leave From	___/___/___ To ___/___/___	☐ Yes	☐ No
Leave without Pay From	___/___/___ To ___/___/___	☐ Yes	☐ No
Work From	___/___/___ To ___/___/___	☐ Yes	☐ No

If intermittent, complete Form CA-7a, Time Analysis Sheet.

If leave buy back, also submit completed Form CA-7b.

SECTION 13 Did employee return to work? ☐ Yes ☐ No

If Yes, date ___/___/___

If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?

☐ Yes ☐ No If No, explain: _____

SECTION 14 Remarks:

SECTION 15 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with 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 this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature _____ (*Agency Official*) Title _____ Date ___/___/___

Name of Agency _____

If OWCP needs specific pay information, the person who should be contacted is:

Name _____ Title _____

Telephone No. (___) ___-_____ Fax No. (___) _____ E-Mail Address _____