UNITED STATES POSTAL SERVICE ®

Supervisor's Training for the Employees' Compensation Operations and Management Portal (ECOMP)

Western Area

https://www.ecomp.dol.gov

ECOMP OVERVIEW

E-COMP is a web-based application accessible via the DOL public internet site, which is intended to allow injured federal workers and their employers to:

- Electronically file CA-1/2, CA-7, CA-7a, and CA-3 forms from either a personal computer, a tablet, a cellphone or a Postal computer;
- Track the exact status of any form or document submitted via E-COMP (e.g., Pending Supervisor Approval, with Agency Reviewer, Received by OWCP, etc.); and
- Electronically upload and submit documents to OWCP case files.

ECOMP Filing Process

- The employee registers for an account in ECOMP. Upon registering, they will be allowed to file CA-1, CA-2 or CA-7 to claim FECA benefits.
- Upon the employee completing the form in ECOMP, the form is routed to the supervisor for completion.
- Once the supervisor has completed their portion, the form is routed to the Agency Reviewer (HRM Office) for review.
- Once the form has been reviewed by the HRM Office, it is electronically submitted to OWCP.
- The Agency Reviewer (HRM Office) may also initiate forms on behalf of the employees.

The following forms may be submitted via ECOMP:

- Form CA-1, Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
- Form CA-2, Notice of Occupational Disease and Claim for Compensation
- Form CA-7, Claim for Compensation
- Form CA-7a, Time Analysis Form
- Form CA-3, Report of Termination of Disability and/or Payment

User Roles in ECOMP:

Agency Maintenance User

- ECOMP Power User at the Agency. This role maintains the agency structure and manages Agency Reviewer (AR) accounts.

Agency Reviewer

- Agency injury compensation specialist (HRM personnel). Users with this role are the last stop for all forms before submission to OWCP.

Employee

- Employees self register in ECOMP and maintain their own accounts.

Supervisor

- Receive all of their forms in ECOMP via email links. These users do not have User IDs or passwords to create or maintain.

Supervisor's responsibility:

- Ensure that your injured employee has an active Ace Logon ID. If not, it must be requested and/or re-activated through eAccess.
- If requested, ensure that the employee has access to a postal computer and adequate time to complete the claim in ECOMP.
- If necessary, assign the employee ECOMP access through eAccess.
- Ensure that all other normal reporting procedures are followed. All accidents must still be entered into the EHS system, submitted on the front end, and all documents must be printed as in the past.

Employee ACE Logon IDs:

- All accounts must be active in order to access a Postal Network.
- If an account has been de-activated, the supervisor must re-activate the employee's account through eAccess.
- If the employee does not have an ACE Login ID, the supervisor must request access through eAccess.
- The Initial Ace Logon password is "UspsAcePassXXXX" (XXXX = last 4 of social).
- Passwords can be reset one of three ways:
  - Telephone
  - Manager Password Reset Request
  - Password Recovery Settings – ePRS

Employee Access to ECOMP via Postal Network:

- The supervisor requests ECOMP for the employee through eAccess if the employee did not have an ACE Login ID.
- The employee will access the “Virtual Kiosk”, created by the USPS IT group, using their ACE Logon ID.
- Upon logging into the “Virtual Kiosk”, the employee will access Internet Explorer and will be directed to the ECOMP website only.
- ACE Logon IDs not used within 90 days will be deactivated and can be reset by the employee’s administrative supervisor.

Employee Access to ECOMP via Postal Network - cont.:

- If the employee already had an ACE Login ID, they will not need the "Virtual Kiosk". They can simply use the Internet to access URL www.ecomp.dol.gov.
- First-Time users to ECOMP will need to register. When registering they will need to select their Department/Agency, Duty Station and enter their supervisor's email address.
- Returning users to ECOMP will sign in with credentials received when they initially registered.
- ECOMP is user friendly.

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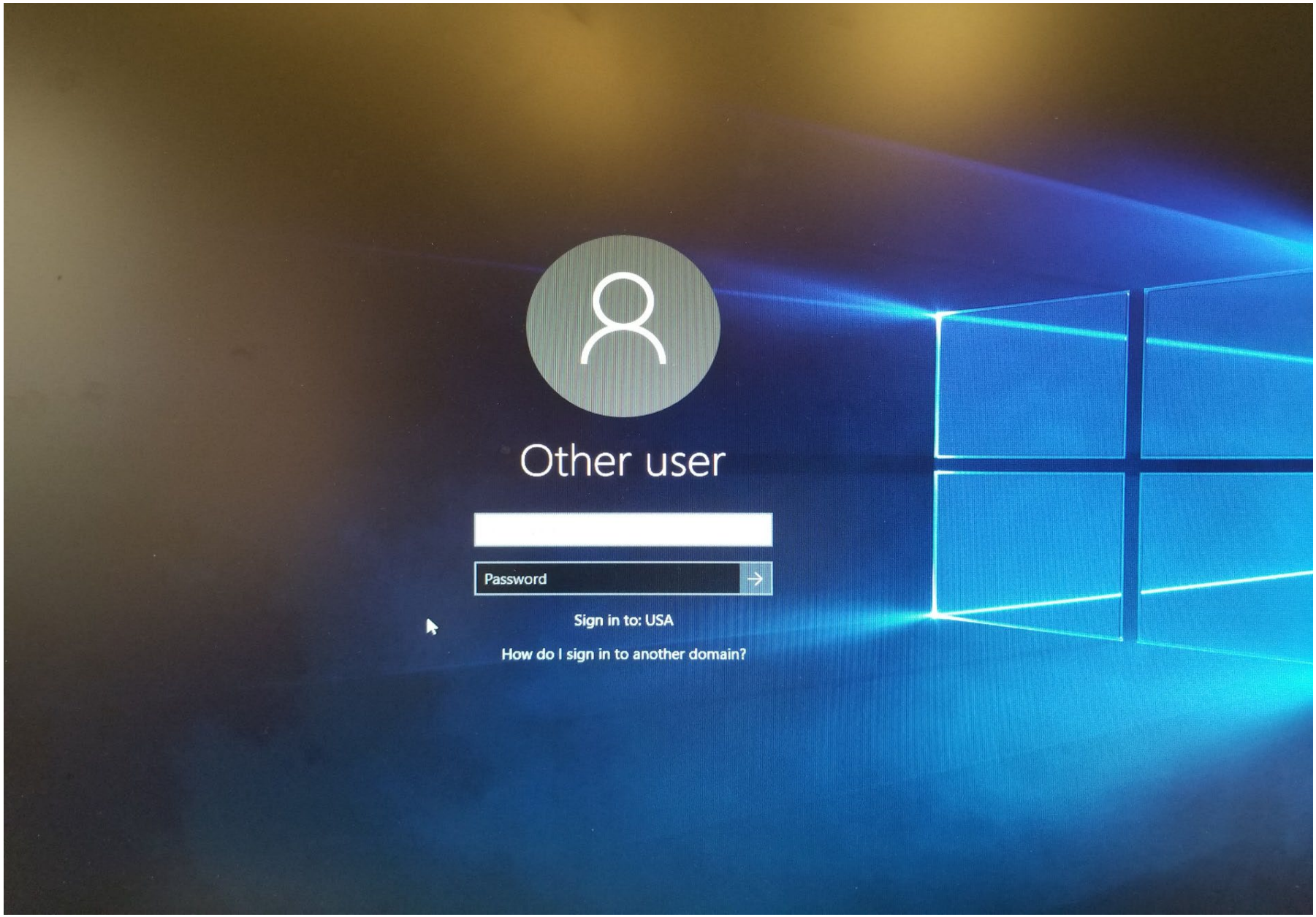
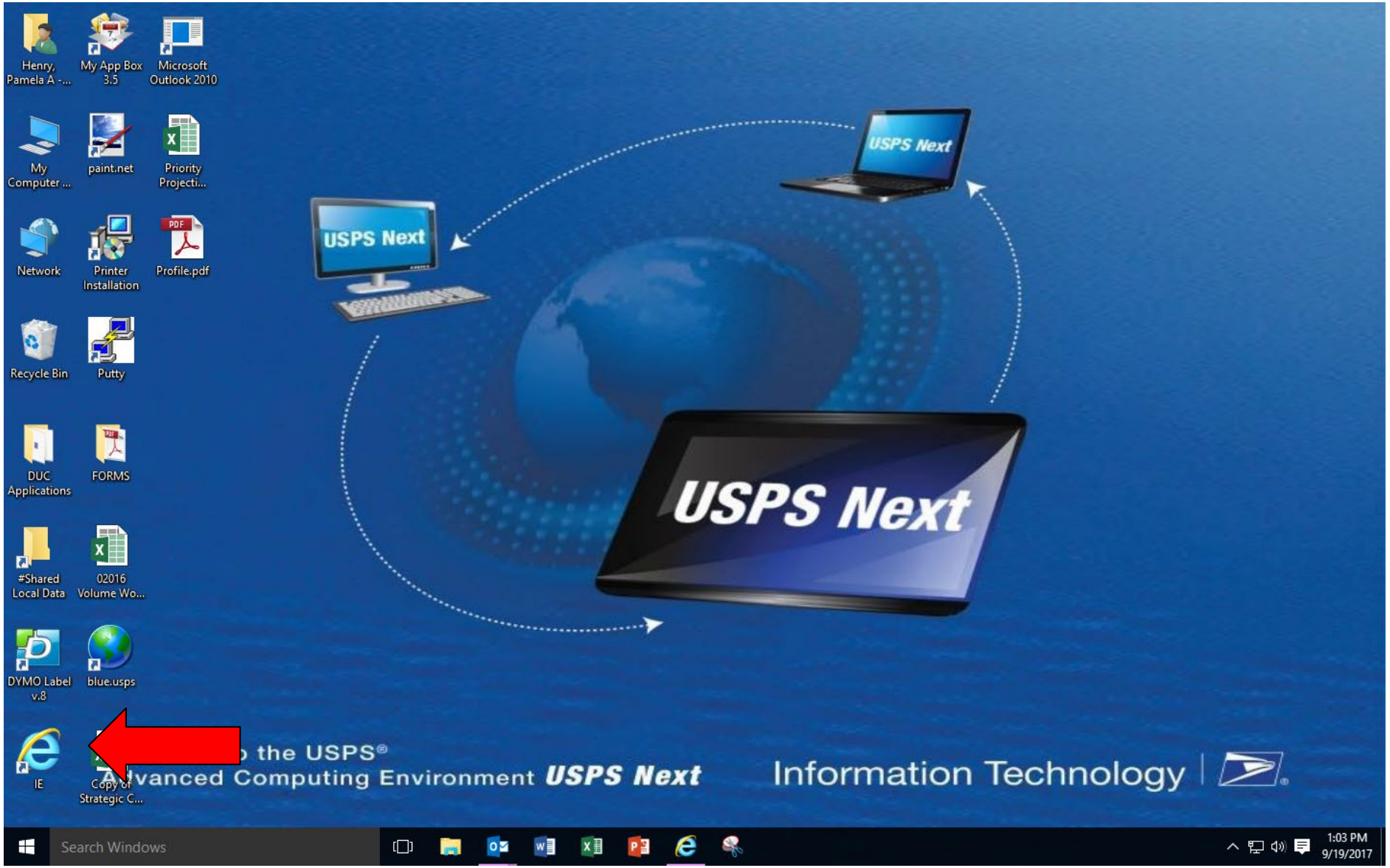
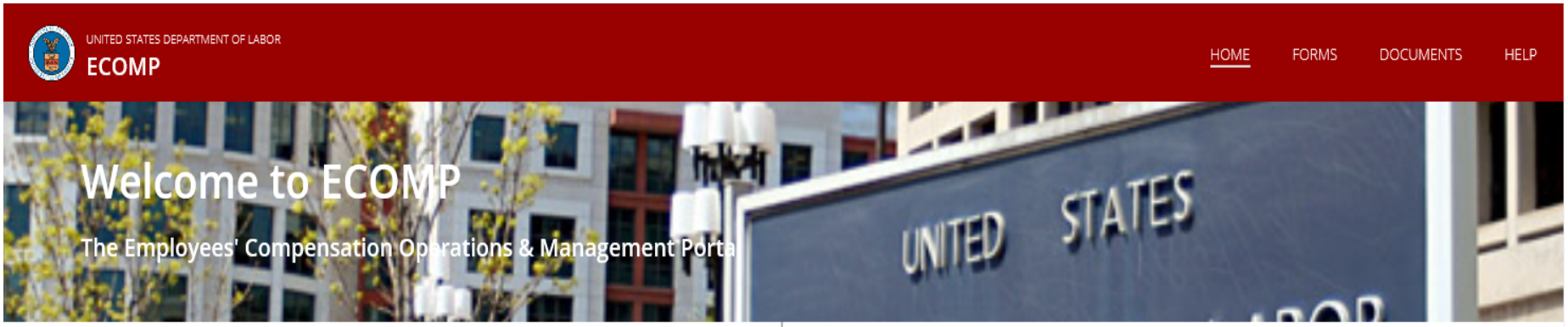


UNITED STATES POSTAL SERVICE ®



UNITED STATES POSTAL SERVICE ®

www.ecomp.dol.gov



Have you been hurt on the job?

If you are a Federal Employee or a Contractor and have sustained a work-related injury or illness, use ECOMP to report the incident to your supervisor.

If you are a Federal Employee you may also file a claim for benefits under the Federal Employees' Compensation Act (FECA). Depending upon your agency, start by filing OSHA's Form 301, then file a claim using either form CA-1 (for traumatic injury) or form CA-2 (for occupational disease). After you have received an official FECA case number, you may also file form CA-7 (Claim for Compensation).

Need to upload a document?

Stakeholders and interested parties can use ECOMP to upload documents to active FECA cases. You can upload letters, medical reports and other supporting documentation. You will need the official FECA Case Number and other identifying information to use this feature.

⚠ Do not upload OWCP forms or medical bills! Forms or bills submitted as uploads will not be processed. Submit medical bills here.

UPLOAD DOCUMENTS

Need to file a form?

Register for an account or sign in to get started!

Sign In

Email or Username

Password

SIGN IN

Forgot password?

Need an account? Register

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Employee Registration

1 REGISTER — 2 VERIFY EMAIL

REGISTER FOR ECOMP

Your ECOMP account enables you to file and manage forms with the Department of Labor OWCP. Your account is covered under the Privacy Act. If you already have an account, sign in here.

ACCOUNT BASICS

First Name | Middle Name (optional) | Last Name

Home Telephone ☐ International

Email Address

Social Security Number | Confirm SSN

☐ I am **NOT** a US citizen and do not have a social security number.

GOVERNMENT ORGANIZATION

What part of the government were you working for at the time of your injury?

Select Department: DEPARTMENT OF LABOR

Filter by State (optional) | Select Agency Group: OWCP

Select Agency: DIVISION OF FEDERAL EMPLOYEES' COMPENSATION (DFEC)

Select Duty Station: DFEC-NATL OFFICE-DISTRICT 25-HEARINGS REVIEW

You can file forms OSHA-301, CA-1, CA-2, CA-3, CA-6, CA-7, CA-7a, CA-16 for this organization through ECOMP

WHO SHOULD REVIEW YOUR FORM?

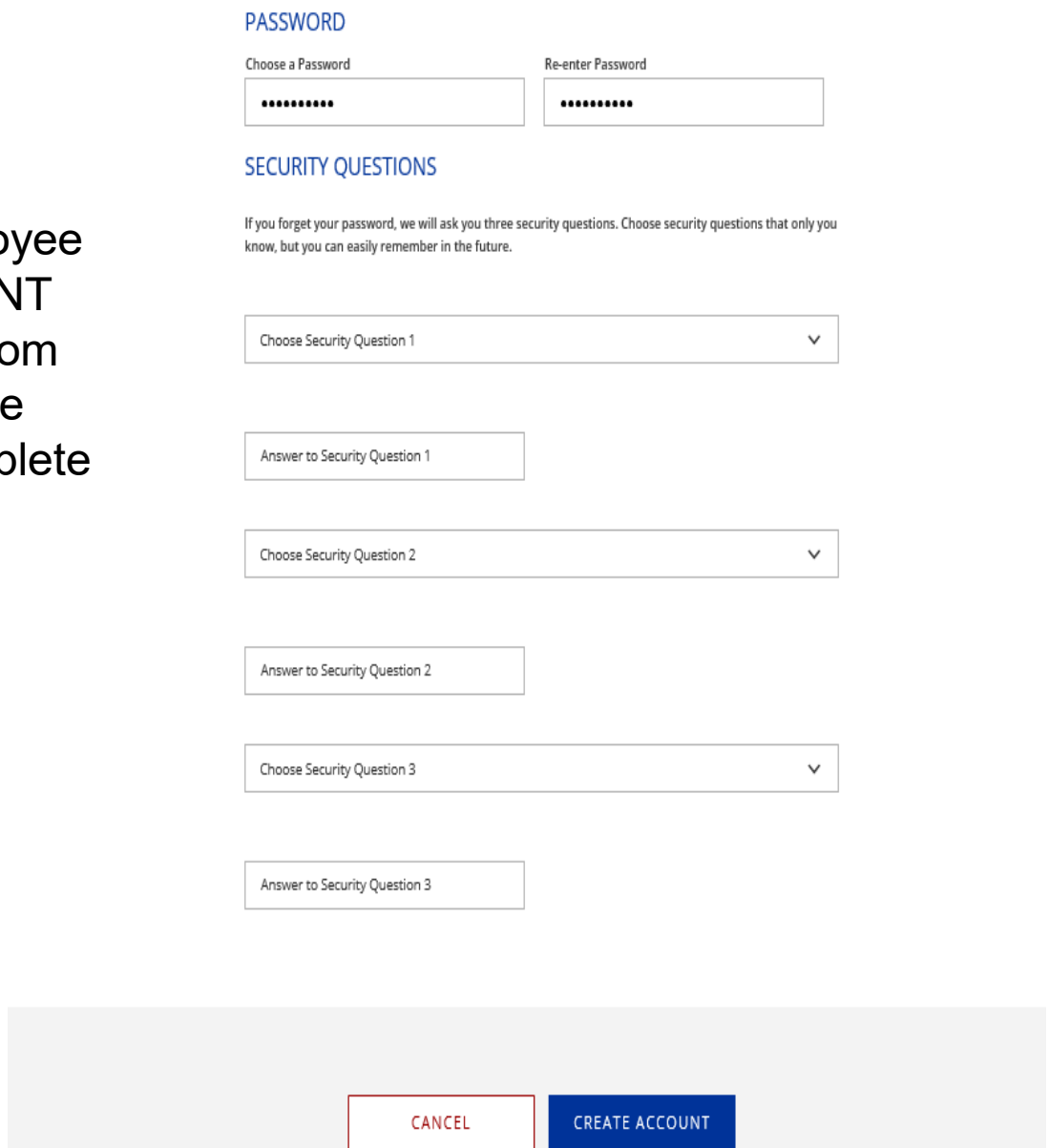
Immediate Supervisor's Email | Select Email Domain: (ex. @dol.gov)

PASSWORD

Choose a Password | Re-enter Password

SECURITY QUESTIONS

Immediately after the employee clicks on CREATE ACCOUNT they will receive an email from ECOMP. They must click the link within the email to complete their registration.



About Forms CA-1 and CA-2

Which forms should I use?

Form **CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occuring during one work shift.

Form **CA-2 (Notice of Occupational Disease and Claim for Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occuring over more than one work shift.

How do I file the form?

The process for filing a form involves completing several form sections made up of smaller form-filing steps. These individual steps can be viewed in the navigation bar on the left. Unless otherwise noted, all of the fields in the form must be completed.

If you filed an **OSHA-301**, the information you entered in that form will be used to automatically fill in matching fields on the FECA form, but you should edit any of the narrative responses as needed.

The form may be saved at any time and completed later. Once the form has been submitted, it will be reviewed by the employee's supervisor and/or the Agency Reviewer before submission to OWCP (if appropriate).

FILE A CA-1 OR CA-2

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Select CA-1 or CA-2

There are two types of injury claims that may be filed: **CA-1** or **CA-2**. Only one claim (either Form **CA-1** or Form **CA-2**) may be filed based on a single incident. If your agency requires a Form **OSHA-301** prior to filing a FECA claim, this means that only one FECA claim form may be filed per **OSHA-301**.

Select the appropriate form:

CA-1 — For Traumatic Injury

CA-1 - Federal Employee's Notice of Traumatic Injury & Claim for Continuation of Pay/Compensation

Use this form if you have sustained a traumatic injury on the job. A traumatic injury is a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift.

Examples of a traumatic injury include: a dog bite, a motor vehicle accident or a slip and fall.

SELECT & CONTINUE

CA-2 — For Illness

CA-2 - Notice of Occupational Disease and Claim for Compensation

Use this form if you have sustained an occupational disease as a result of your job duties. An occupational disease or illness is a condition produced by the work environment over a period longer than a single workday or shift.

Examples of an occupational disease include: noise induced hearing loss, asbestos-related illness or orthopedic injuries due to repetitive motion.

SELECT & CONTINUE

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1 BASICS — 2 INJURY — 3 WITNESS — 4 ATTACHMENTS — 5 REVIEW — 6 SIGN

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Welcome to CA-1. The steps in this form are listed in the navigator above. Unless otherwise noted, you must complete all fields. Start by filling out your basic information below.

EMPLOYEE BASICS

Employee First Name: Injured
Middle Name (optional):
Last Name: Worker

1a Employee Email: injuredworker.ecomp@outlook.com

Social Security Number: •••-••-••••
Confirm SSN: •••-••-••••

Date of Birth: 06/06/1975

Sex: Male | Female

Home Telephone: (202) 555-1234
☐ International

Grade as of Date of Injury: 9
Step as of Date of Injury: 5

HOME MAILING ADDRESS

Address: 123 A St

City: Washington
State: DC - District Of Columbia

ZIP code: 20010
Country: UNITED STATES OF AMERICA

DEPENDENTS

☐ Wife, Husband
☐ Children Under 18 Years
☐ Other
☑ None

WHO SHOULD REVIEW THIS FORM?

Immediate Supervisor's Email: sue.supervisor
Select Email Domain: @dol.gov

Autosaved

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BASICS (1) — INJURY (2) — WITNESS (3) — ATTACHMENTS (4) — REVIEW (5) — SIGN (6)

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Describe the details of employee's injury.

DESCRIPTION OF INJURY

Place where event occurred

(9) FPB Building

3rd Floor

Address

200 C Street

City

Washington

State

DC - District Of Columbia

ZIP code

20010

Country

UNITED STATES OF AMERICA

DATE

Date Injury Occurred

(10) 04/01/2019

Time Injury Occurred

10:00 am

(11) Date of this Notice

If you submit this form today, it will be filed on 04/08/2019.

(12) Employee's Occupation

INJURY

The next two fields have been defaulted from the OSHA-301 form, if present. Please edit if necessary.

Cause of Injury (Describe what happened and why)

(13) Lifting a box of files I strained my back

(469 characters remaining)

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

(14) Low back strain

(235 characters remaining)

Autosaved

UNITED STATES POSTAL SERVICE ®

BASICS ✓ | INJURY ✓ | 3 WITNESS | 4 ATTACHMENTS | 5 REVIEW | 6 SIGN

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

*** This step is optional.** If you have a statement from a witness who was present at the time of the event, you can upload that statement in the next step. Enter the witness information here. If you do not have a witness statement, you can skip this step by clicking the forward arrow below.

WITNESS (optional)

16 Witness First Name | Middle Name (optional) | Last Name

Address

City | State

Country

ZIP code | UNITED STATES OF AMERICA

Date of Witness Statement

(mm/dd/yyyy)

Autosaved

UNITED STATES POSTAL SERVICE ®

BASICS ✓ — INJURY ✓ — WITNESS ✓ — 4 ATTACHMENTS — 5 REVIEW — 6 SIGN

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

*** This step is optional.** You can attach supporting documents to this claim now, or submit them at a later date through ECOMP once a claim number has been assigned. Examples of supporting documents include witness statements, job descriptions, and medical documentation.

NOTE: Do not upload OWCP forms or medical bills here; they will not be processed. Medical bills should be submitted using OWCP's Central Bill Processing Center and OWCP forms should be submitted through your agency's established procedures (either electronically or in paper format). Forms or bills submitted as uploads will not be processed.

ATTACHMENTS (optional) ⓘ

Max file size is 5MB

Limit number of pages to 10 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx

CHOOSE A FILE

Autosaved

UNITED STATES POSTAL SERVICE ®

BASICS ✓ — INJURY ✓ — WITNESS ✓ — ATTACHMENTS ✓ — 5 REVIEW — 6 SIGN

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

EMPLOYEE BASICS

Edit

1 **Employee First Name**: Injured
Middle Name:
Last Name: Worker

1a **Employee Email**
injuredworker.ecomp@outlook.com

Government Organization
XX ECOMP TEST (DO NOT USE)
OFFICE OF ECOMP TESTING
C/O ECOMP - XX TEST
203 UNION STREET, WASHINGTON, DC, 20210

2 **Social Security Number**
•••-••-••••

3 **Date of Birth**
06/06/1975

4 **Sex**
Male

5 **Home Telephone**
(202) 555-1234

6 **Grade as of Date of Injury**: 9
Step as of Date of Injury: 5

12 **Employee's Occupation**
Claims Examiner

Edit

INJURY

Edit

13 **Cause of Injury**
Lifting a box of files I strained my back

14 **Nature of Injury**
Low back strain

WITNESS

Edit

16 **Witness First Name**: *NO RESPONSE GIVEN*
Middle Name:
Last Name: *NO RESPONSE GIVEN*

Address
NO RESPONSE GIVEN

Date of Witness Statement
NO RESPONSE GIVEN

ATTACHMENTS

Add/Modify Attachments


View

DCN 119489
Type: General Inquiry (Non-Medical) | Authored Date: 04/03/2019
Uploaded by injuredworker.ecomp@outlook.com on 04/08/2019 at 3:44 PM

UNITED STATES POSTAL SERVICE ®

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

SIGN & FILE FORM

17 **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:

- [x] **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.

Submitting this form is considered the same as signing it.

< EXIT SIGN AND FILE

UNITED STATES POSTAL SERVICE ®

CA-1 Traumatic Injury Claim

ECN 119488 | Draft

Attention

I understand that any person who knowingly makes any false statements, 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 entitles 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. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.

I AGREE

CANCEL

EXIT

SIGN AND FILE

UNITED STATES POSTAL SERVICE ®

This form has been forwarded for review.

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

FORM LOCKED

ECN 119488 | CA-1 — ***Pending Review by Supervisor***

Employee	Injured Worker	**Date of Event**	04/01/2019
Organization	OFFICE OF ECOMP TESTING	**Initiated**	04/08/2019

View | Upload Attachments | Get PDF

- An email has been sent to your supervisor's email account at **sue.supervisor@dol.gov**
- You will receive email updates each time the status of this form changes.
- Make sure to save/print a copy for your records and note the ECN (ECOMP Control Number).

Next Steps

- After your claim is reviewed by your supervisor and is received by DFEC, you will receive an email providing a Case Number.
- You can use that case number to file a CA-7, claim for compensation.
- If you want to check on the status of your claim, visit your dashboard.

DONE

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EMPLOYEE DASHBOARD

You have 30 forms & claims

Each form you file will appear in this list and be assigned a unique ECOMP Control Number. Use the E C N to track the status of your ECOMP forms.

For FECA forms, the E C N will be replaced with a Case Number once the form has been submitted to OWCP. Reference the Case Number in all communications with OWCP regarding your case.

GET STARTED: FILE A FORM

FILE CA-7 FOR CASE NOT LISTED

FORM LOCKED

ECN 119488 | CA-1 — ***Pending Review by Supervisor***

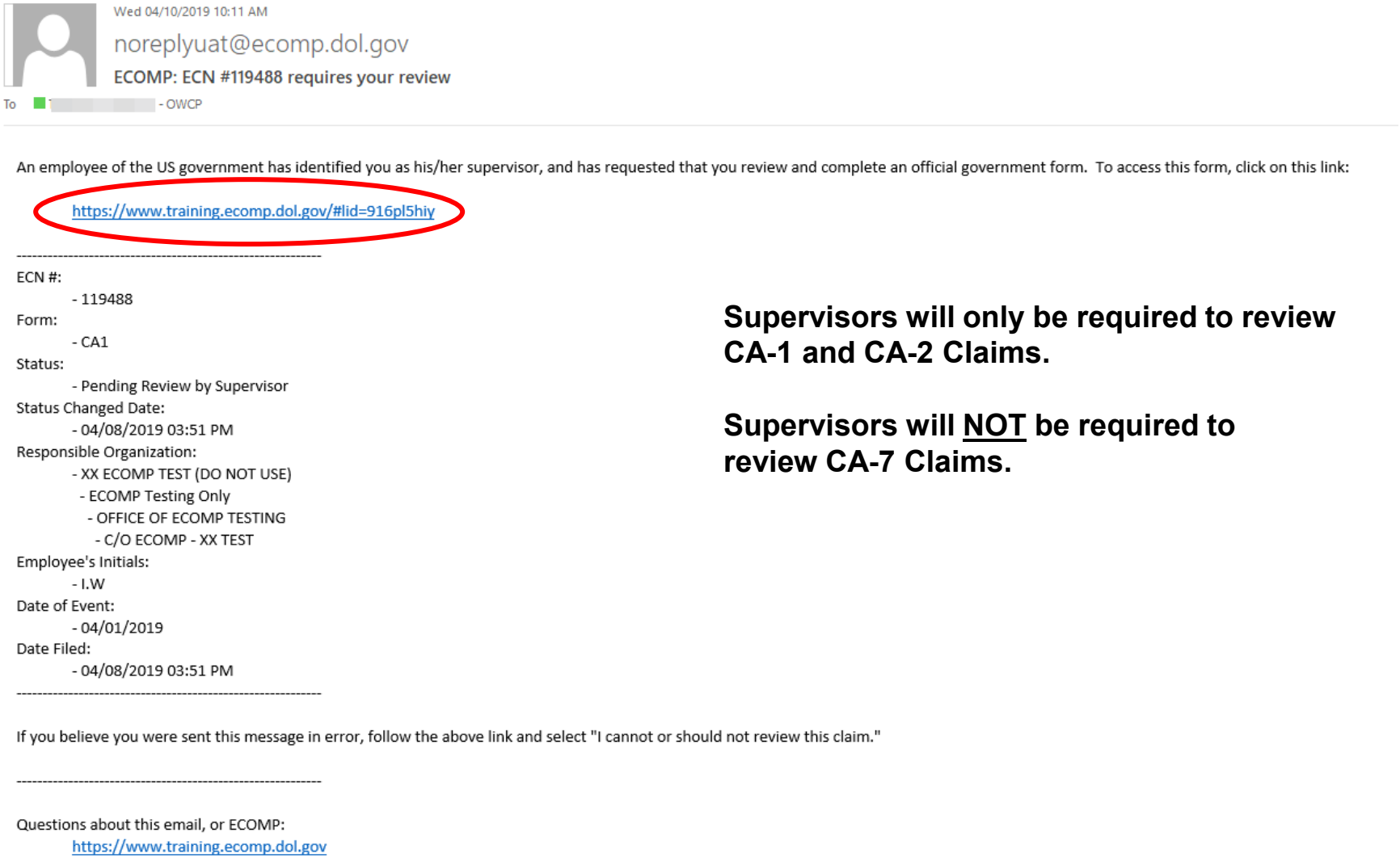
Employee Injured Worker
Organization 0000-XX OFFICE OF ECOMP TESTING

Date of Event 04/01/2019
Initiated 04/08/2019

View Get PDF Next Steps

Filing a CA-1 or CA-2: Email to Supervisor

The supervisor begins the review by clicking their email link.



Wed 04/10/2019 10:11 AM

noreplyuat@ecomp.dol.gov

ECOMP: ECN #119488 requires your review

To [redacted] - OWCP

An employee of the US government has identified you as his/her supervisor, and has requested that you review and complete an official government form. To access this form, click on this link:

https://www.training.ecomp.dol.gov/#lid=916pl5hiy

ECN #:
- 119488

Form:
- CA1

Status:
- Pending Review by Supervisor

Status Changed Date:
- 04/08/2019 03:51 PM

Responsible Organization:
- XX ECOMP TEST (DO NOT USE)
  - ECOMP Testing Only
    - OFFICE OF ECOMP TESTING
      - C/O ECOMP - XX TEST

Employee's Initials:
- I.W

Date of Event:
- 04/01/2019

Date Filed:
- 04/08/2019 03:51 PM

If you believe you were sent this message in error, follow the above link and select "I cannot or should not review this claim."

Questions about this email, or ECOMP:
https://www.training.ecomp.dol.gov

Supervisors will only be required to review CA-1 and CA-2 Claims.

Supervisors will <u>NOT</u> be required to review CA-7 Claims.

Rules of Behavior

Before using ECOMP, you must read and agree to the following Rules of Behavior.

Restricted Use:

- Users shall access ECOMP and utilize its information solely for ECOMP related business.

Access:

- Users shall access and use only information for which they have official authorization.
- Users shall limit sharing of ECOMP information only with users who have the need to know, in regard to ECOMP related business.

Accountability:

- Users shall acknowledge actions and accept responsibility for correcting errors and rectifying problems.
- Users shall log out of the ECOMP web site when finished using the system or leaving their computers.

Confidentiality:

- Users shall encrypt ECOMP data with the latest approved encryption technology when storing or transmitting.
- Users shall protect physical copies from getting lost and not leave printouts unattended.
- Users shall prevent unauthorized people from viewing the information whether on the computer screen or on paper.
- Users shall make sure that they understand their responsibilities under the Privacy Act to protect information that is transmitted through and resides in the ECOMP system from improper disclosure.

Integrity:

- Users shall make sure that the information which they manage, and for which they have responsibility, is accurate and up-to-date.
- Users shall prevent unauthorized changes, destruction or tampering with information.
- Users shall create only authorized records.

Passwords and User IDs:

- Users shall never share passwords or account information.
- Users shall use only the user accounts to which they have been assigned to access the system.
- Users shall protect their accounts by memorizing their passwords and never write them on paper or store them in an electronic file.
- Users shall change their passwords immediately should they suspect that someone else knows their passwords.

Awareness:

- Users shall complete the annual security training provided by their employer.
- Users shall maintain up-to-date essential knowledge of computer security.

Reporting:

- Users shall immediately report security vulnerabilities and violations to proper authorities and their ECOMP Representatives.
- Users shall immediately report accidental or intentional disclosure of ECOMP information to proper authorities and their ECOMP Representatives.

Penalties for Non-compliance:
Users who do not comply with the ROB are subject to penalties that can be imposed under existing policy and regulations, including

- official written reprimands
- suspension of system privileges
- temporary suspension from duty
- removal from current position
- termination of employment
- criminal prosecution

OWCP will enforce the use of penalties against any user who willfully violates any OWCP, Department, or Federal system security (and related) policy.
Click here to view the complete Rules of Behavior document.

☑ I have read the above document and agree to these Rules of Behavior

NEXT

Filing a CA-1 or CA-2: Supervisor Portion

Supervisor Review

You have been named by an employee of the US government to review this form. You're being asked to fill this out as an employee's supervisor so it may reference you throughout as 'The Supervisor.'

ECN 119488 | CA-1		*Pending Review by Supervisor*	
Employee	Injured Worker	**Date of Event**	**04/01/2019**
Organization	OFFICE OF ECOMP TESTING	**Initiated**	**04/08/2019**

You should review this form if both of these are true:

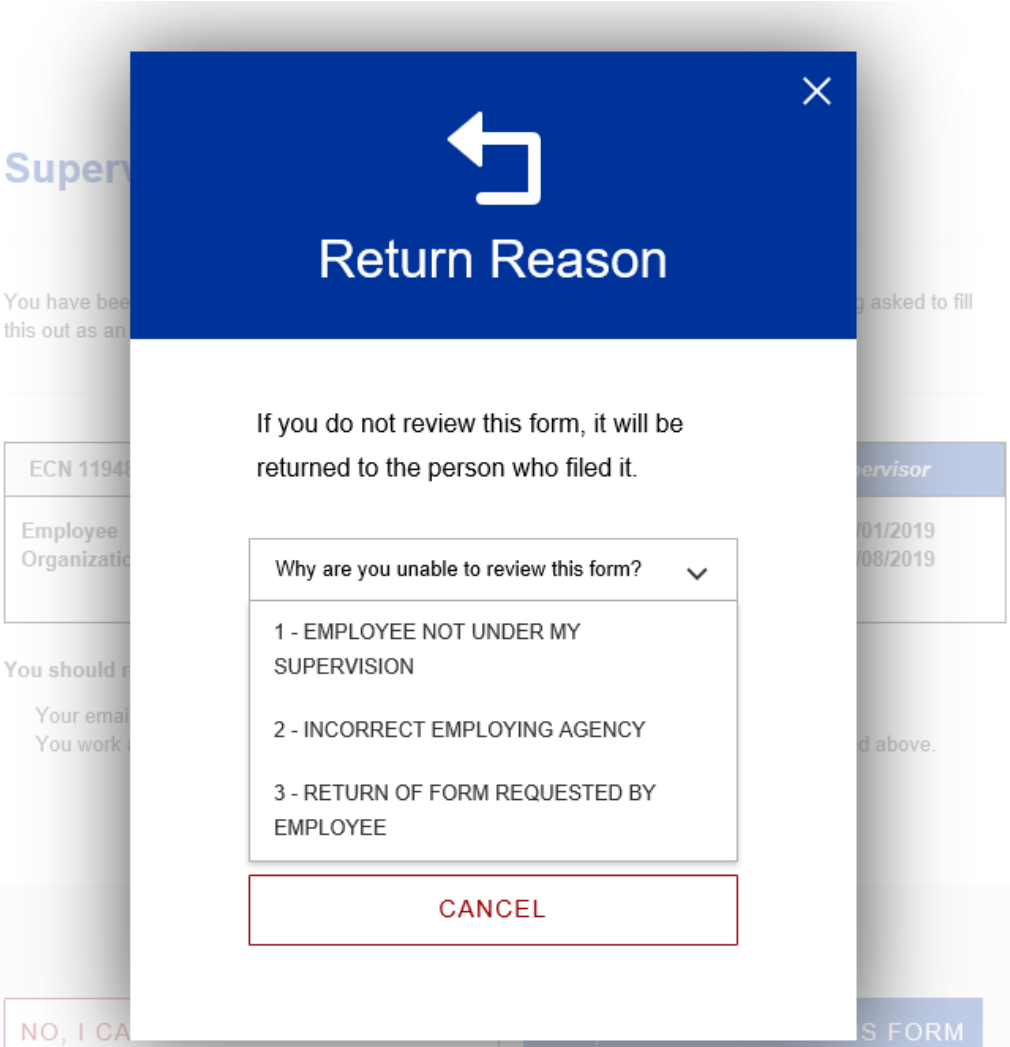
Your email is [redacted]**@dol.gov**
You work as a supervisor at the **XX ECOMP TEST (DO NOT USE)** for the employee named above.

NO, I CANNOT REVIEW THIS FORM

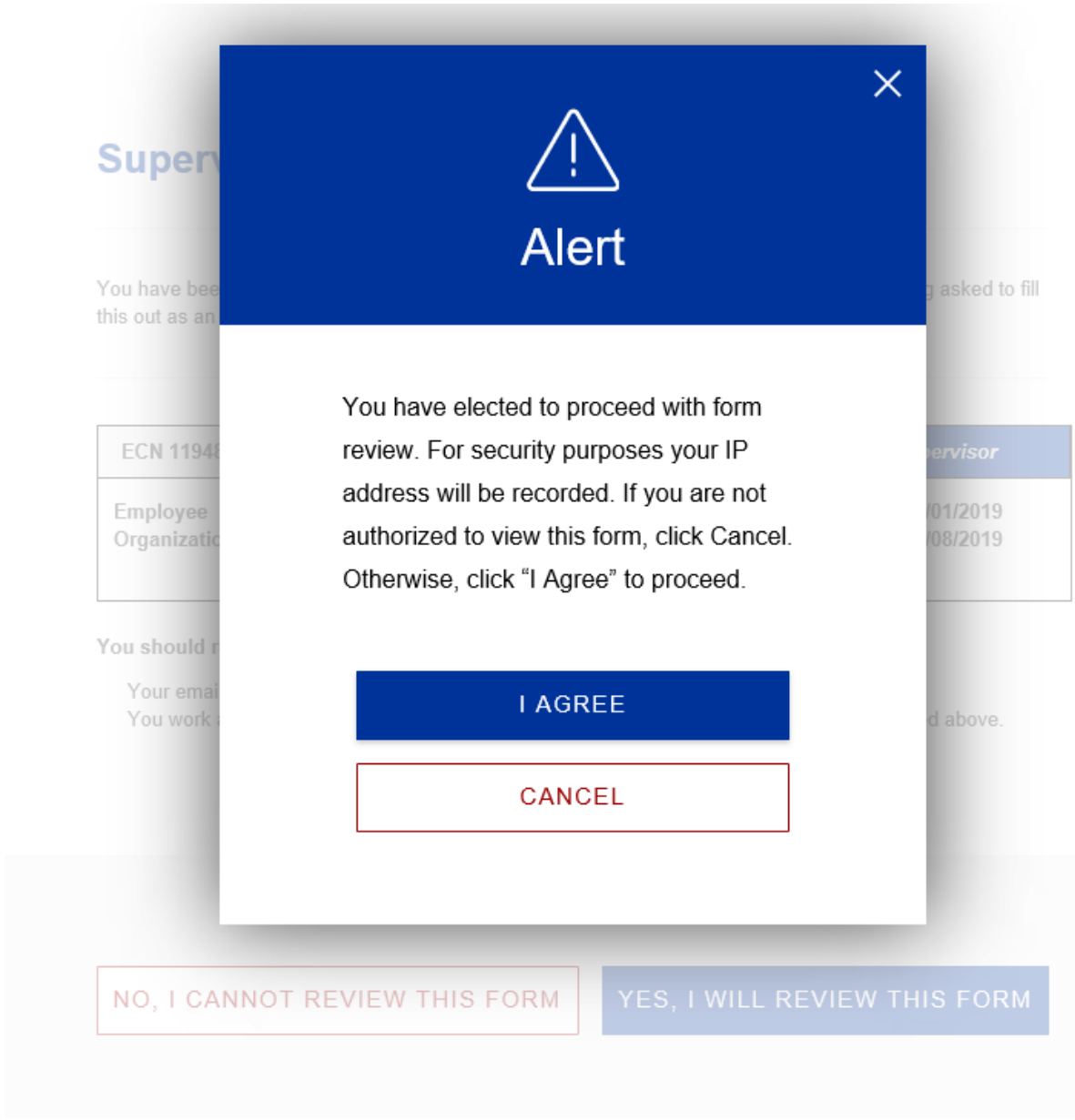
YES, I WILL REVIEW THIS FORM

Filing a CA-1 or CA-2: Supervisor Portion

Either reason returns the form to the employee and the AR is notified via email.



Filing a CA-1 or CA-2: Supervisor Portion



Filing a CA-1 or CA-2: Supervisor Portion

SUMMARY (✓) — 2 REVIEW CA-1 — 3 SUPERVISOR — 4 BASICS — 5 INJURY — 6 PHYSICIAN & WITNESSES

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

Be sure to carefully review this form before continuing.

EMPLOYEE BASICS

(1) **Employee First Name** Injured — **Middle Name** — **Last Name** Worker

(1a) **Employee Email**
injuredworker.ecomp@outlook.com

Government Organization
XX ECOMP TEST (DO NOT USE)
OFFICE OF ECOMP TESTING
C/O ECOMP - XX TEST
203 UNION STREET, WASHINGTON, DC, 20210

(2) **Social Security Number**
•••-••-••••

(3) **Date of Birth**
••/••/••••

(4) **Sex**
Male

(5) **Home Telephone**
(202) 555-1234

(6) **Grade as of Date of Injury**
9

Step as of Date of Injury
5

HOME MAILING ADDRESS

(7) **Address**
••••••••••••••, •••••••••, ••, •••••, •••••• •••••• •• •••••••

(8) DEPENDENTS

No dependents have been selected

WHO SHOULD REVIEW THIS FORM?

Immediate Supervisor's Email
[redacted]@dol.gov

DESCRIPTION OF INJURY

(9) **Place where injury occurred**
FPB Building, 3rd Floor, 200 C Street, Washington, DC, 20010, UNITED STATES OF AMERICA

Filing a CA-1 or CA-2: Supervisor Portion

DATE

10 **Date Injury Occurred**

04/01/2019 10:00 am

11 **Date of this Notice**

04/08/2019

12 **Employee's Occupation**

Claims Examiner

INJURY

13 **Cause of Injury**

Lifting a box of files I strained my back

14 **Nature of Injury**

Low back strain

WITNESS

16 **Witness First Name** | **Middle Name** | **Last Name**

NO RESPONSE GIVEN | | *NO RESPONSE GIVEN*

Address

NO RESPONSE GIVEN

Date of Witness Statement

NO RESPONSE GIVEN

ATTACHMENTS

Add/Modify Attachments

DCN 119489

Type: General Inquiry (Non-Medical) | Authored Date: 04/03/2019

View

Uploaded by injuredworker.ecomp@outlook.com on 04/08/2019 at 3:44 PM

Autosaved

EXIT

Filing a CA-1 or CA-2: Supervisor Portion

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

SUPERVISOR INFORMATION

Agency Official First Name

(38) Sue

Middle Name (optional)

Last Name

Supervisor

Agency Official Title

Supervisor

Office Telephone

(202) 555-5678

☐ International

(17) AGENCY NAME AND ADDRESS OF REPORTING OFFICE

Agency Name

DOL

Address

200 C St

City

Washington

State

DC - District Of Columbia

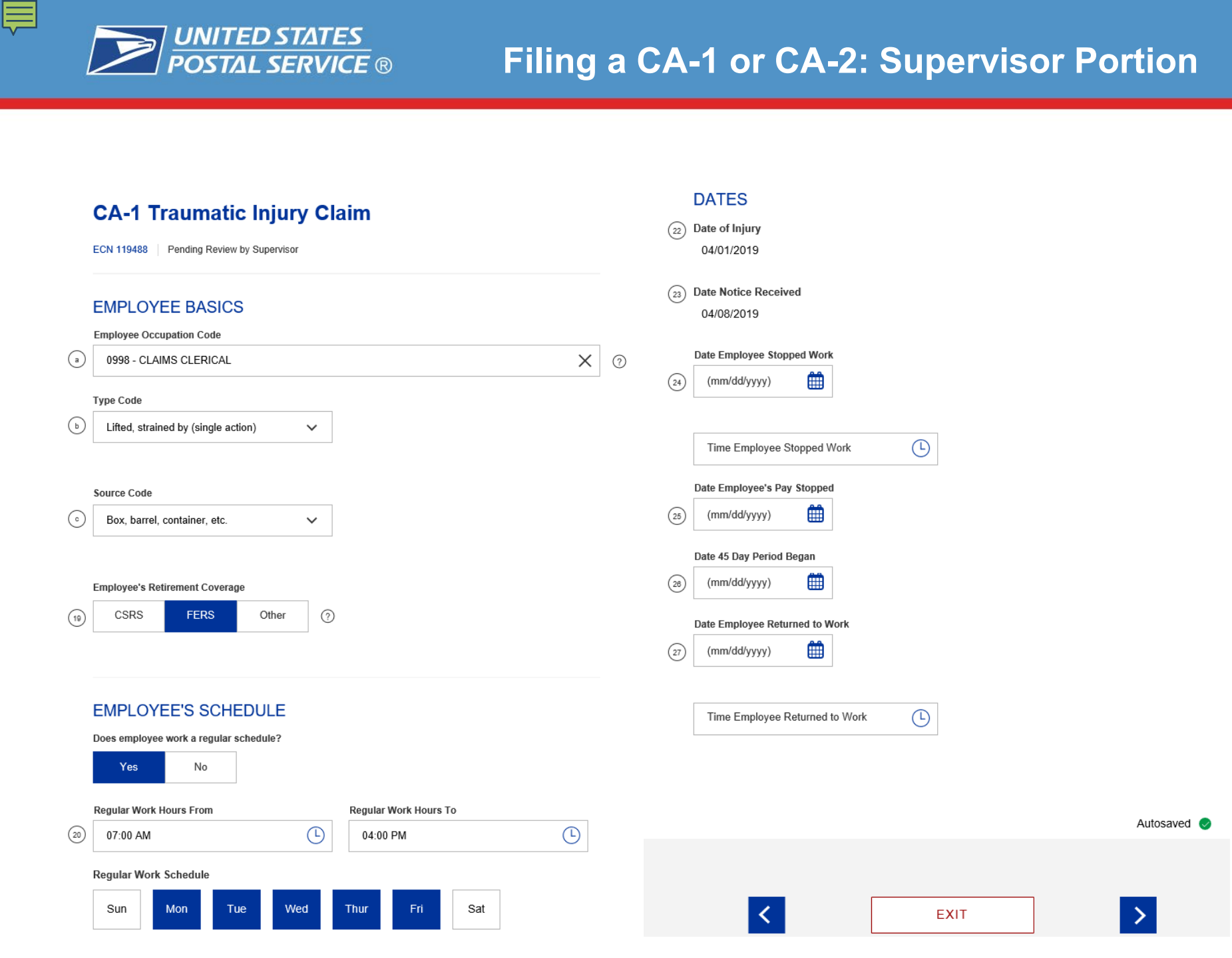
ZIP code

20010

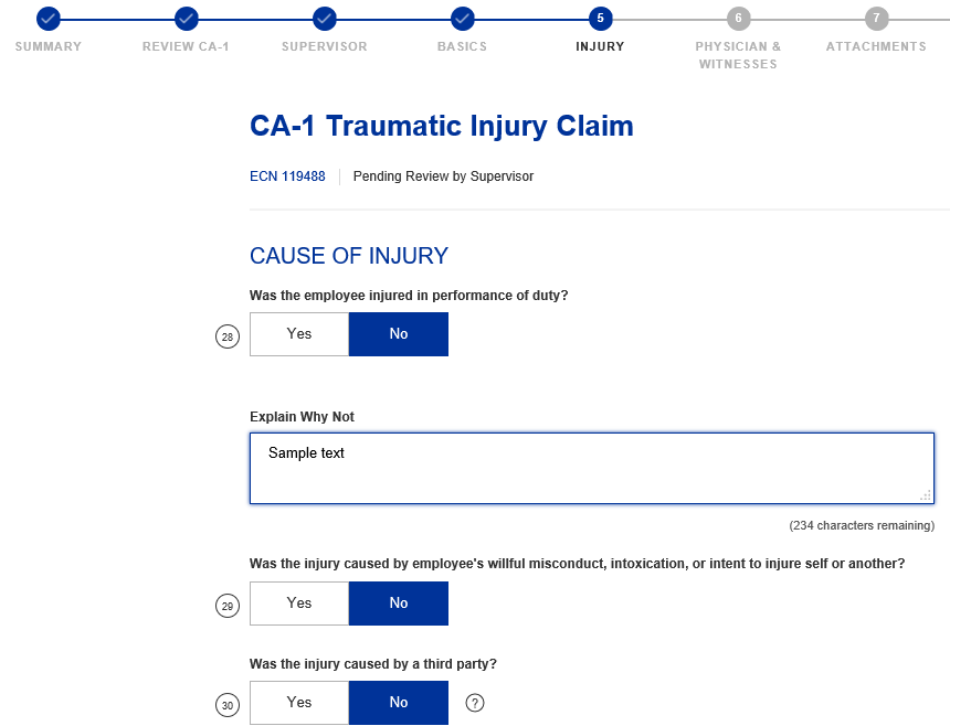
Country

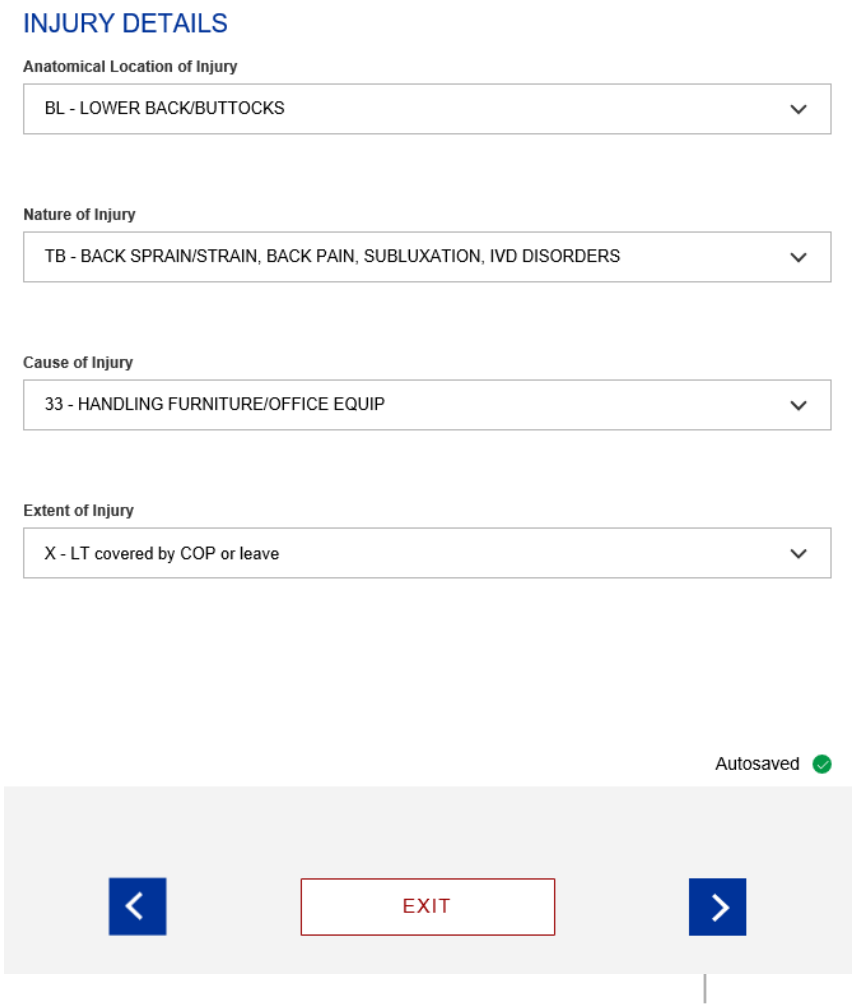
UNITED STATES OF AMERICA

Filing a CA-1 or CA-2: Supervisor Portion



Filing a CA-1 or CA-2: Supervisor Portion





Filing a CA-1 or CA-2: Supervisor Portion

SUMMARY | REVIEW CA-1 | SUPERVISOR | BASICS | INJURY | 6 PHYSICIAN & WITNESSES | 7 ATTACHMENTS

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

PHYSICIAN FIRST PROVIDING MEDICAL CARE

32 First Name | Last Name

Address

City | State

Country

ZIP code | UNITED STATES OF AMERICA

MEDICAL

First Date Medical Care Received

33 (mm/dd/yyyy)

Do medical reports show employee is disabled for work?

34 Yes | No

Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses?

35 Yes | No

If employing agency controverts continuation of pay, state the reason in detail (otherwise, leave blank).

36 Sample text

(239 characters remaining)

37 Pay Rate When Employee Stopped Work | Per

I certify that the information I have given and the information furnished by the employee on this form is true to the best of my knowledge with the following exception:

38 Sample text

(249 characters remaining)

Autosaved

EXIT

Filing a CA-1 or CA-2: Supervisor Portion

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

Attach the following supporting documents: witness statements, job descriptions, and medical documentation. Do not upload OWCP forms or medical bills here; they will not be processed. Submit medical bills using OWCP's Central Bill Processing Center. Submit OWCP forms through your agency's established procedures (electronically or in paper form). Learn more.

ATTACHMENTS (optional)

Max file size is 5MB

Limit number of pages to 10 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx

CHOOSE A FILE

UPLOADED ATTACHMENTS

View

DCN 119489

Type: General Inquiry (Non-Medical) | Authored Date: 04/03/2019

Uploaded by injuredworker.ecomp@outlook.com on 04/08/2019 at 3:44 PM

Filing a CA-1 or CA-2: Supervisor Portion

REVIEW CA-1 | SUPERVISOR | BASICS | INJURY | PHYSICIAN & WITNESSES | ATTACHMENTS | 8 REVIEW

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

Review this information carefully before continuing.

SUPERVISOR INFO

Edit

(38) **Agency Official First Name** Sue
Middle Name
Last Name Supervisor

Agency Official Title
Supervisor

Email & Office Phone
tukenmez.derek@dol.gov (202) 555-5678

(17) AGENCY NAME AND ADDRESS OF REPORTING OFFICE

Edit

Agency Name
DOL

Address
200 C St, Washington, DC, 20010, UNITED STATES OF AMERICA

(35) **Does supervisor agree?**
Yes

(36) **Does agency controvert continuation of pay?** Edit
Sample text

(37) **Pay Rate**
NO RESPONSE GIVEN

(38) **Remarks** Edit
Sample text

ATTACHMENTS

Add/Modify Attachments

View
DCN 119489
Type: General Inquiry (Non-Medical) | Authored Date: 04/03/2019
Uploaded by injuredworker.ecomp@outlook.com on 04/08/2019 at 3:44 PM

EXIT

Filing a CA-1 or CA-2: Supervisor Portion

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

SIGN

Action to Take

Sign & Forward or File | Request Resubmission

EVENT (optional)

Is this form related to one of these events? (optional)

EXIT | SIGN AND FORWARD

Filing a CA-1 or CA-2: Supervisor Portion

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Review by Supervisor

SIGN

Action to Take

Sign & Forward or File | Request Resubmission

This form will not be submitted and will be returned to the filer, who will be advised of the return reason.

Why?

1 - Incorrect Employing Agency

2 - Return of form requested by employee

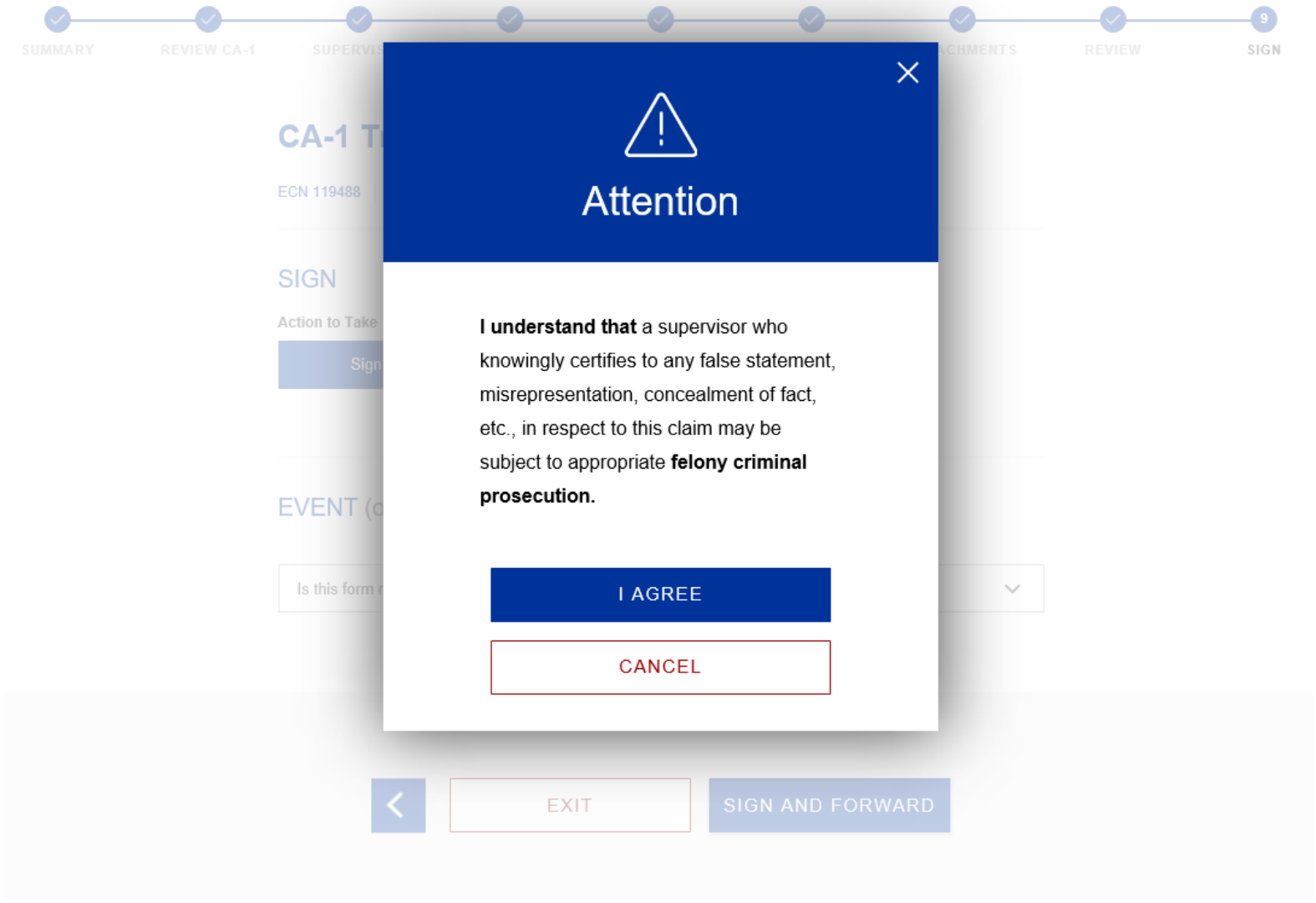
EVENT (optional)

Is this form related to one of these events? (optional)

EXIT | REQUEST RESUBMISSION

Filing a CA-1 or CA-2: Supervisor Portion

The supervisor is warned against submitting fraudulent information.



Filing a CA-1 or CA-2: Supervisor Portion

CA-1 Traumatic Injury Claim

ECN 119488 | Pending Final Review by FECA Agency Reviewer

FORM LOCKED

ECN 119488 | CA-1 — *Pending Final Review by FECA Agency Reviewer*

Employee	Injured Worker	**Date of Event**	**04/01/2019**
Organization	OFFICE OF ECOMP TESTING	**Initiated**	**04/08/2019**

View Get PDF

- You can print a copy of this form using the 'Get PDF' button above.
- A digital copy of this form will be kept by ECOMP for 5 years. (Public Law 91-596 and 29 CFR 1904)

ISSUE CA-16 DONE

Filing a CA-1 or CA-2: Supervisor Portion

Authorization for Examination And/Or Treatment

U.S. Department of Labor
Office of Workers' Compensation Programs

The following request for information is required under (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. 130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. NOTE: THIS FORM IS NOT TO BE REPRODUCED OR DUPLICATED (See Instructions). IF INSTRUCTIONS ARE SEPARATED FROM THIS FORM, REFER TO FORM INFORMATION https://www.dol/owcp/dfec

OMB No.: 1240-004
Expires: 03-31-2021

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service within the meaning of FECA (See Instructions for definition of a qualified physician):

2. Employee's Identification (last, first, middle, SSN)	3. Date of Injury (mo. day, yr.)	4. Occupation

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 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, 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. PLEASE NOTE THIS AUTHORIZATION DOES NOT INCLUDE PRESCRIPTIONS FOR COMPOUND MEDICATIONS OR PHYSICIAN DISPENSED MEDICATION. SEE INSTRUCTIONS FOR ADDITIONAL MEDICAL INFORMATION.

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. Name and Address of Employee's Place of Employment

Department or Agency:

Bureau or Office:

Local Address (Including Zip Code)

9. Local Employing Agency Telephone Number (Including Area Code):

10. Name and Title of Authorized Official (Type or Print Clearly): (See Instructions)

11. Send one copy of your report to:

U.S. DEPARTMENT OF LABOR
DFEC CENTRAL MAILROOM
P.O. BOX 8300

12. I certify that I am the individual authorize
issue this form concerning medical treatment. Further certify that the
information provided above is true and accurate to the best of my knowledge

Authorized Official):

Overview of Reporting Procedures

- When an employee sustains an injury/illness while in the performance of duty, the employee is to notify the supervisor/manager **immediately.**
- The supervisor/manager interviews the employee and investigates the accident.
- The supervisor inputs the injury/illness into EHS immediately (on day of occurrence) once notified by employee or within 24 hours.
- When inputting the injury/illness into EHS, supervisors must ensure the entire process (to include the input of the CA1/2 and the CA-17) is completed prior to submitting the report in EHS. Supervisors MUST ENTER ALL REQUIRED FIELDS into EHS until they reach the **"SUBMIT"** button within the system. An accident is not considered "complete" until the accident information is "submitted in EHS and all pertinent documents are printed."
- Supervisors must provide the employee with the documents from the CA-1/2 Injury Kit which can be obtained on the front end of EHS.
- **Ensure that the injured employee has access to a postal computer and adequate time to complete the claim in the ECOMP system.**
- **Upon receipt of the email notification, immediately go into ECOMP and complete the supervisor's portion of the claim and submit it for review to HRM.**
- **Ensure that once the claim is submitted to OWCP by the Agency Reviewer (HRM), the required signatures are obtained on the claim form and the signed form is returned to the District HRM Office.**
- **For all questions or issues, please immediately contact the District HRM office.**

Benefits for the USPS:

- We can electronically file CA-1/2, CA-7, and CA-7a forms from either a personal computer, a tablet, a cellphone or a Postal computer
- We can track the exact status of any form or document submitted via ECOMP
- We can electronically upload and submit documents to existing claims
- We will receive a claim number generally within 15 minutes of the HRM office reviewing and submitting the claim through ECOMP
- HRM is no longer spending time re-faxing claims to DOL
- DOL will no longer assign injury claims to the wrong district causing a delay in claim management and follow-up medical treatment
- Injured employees will receive faster medical treatment beyond the initial visit because there is no longer a delay for scheduling follow-up medical treatment due to the lack of a claim number

Questions?

If you have any questions, please contact your local Health & Resource Management Office.