Filing for an Occupational Disease

Occupational Disease Defined

An occupational disease (OD) is defined as:

A wound or other condition of the body caused by a specific event or series of events or incidents over more than one work day or work shift.

Form CA-2 [Notice of Occupational Disease and Claim for Compensation] should be completed by the injured worker (IW) and an employing agency (EA) supervisor or injury compensation specialist.

In a case of latent disability, the time for filing a claim does not begin to run until the IW has a compensable disability and is aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship of the compensable disability to his/her employment. In such a case, the time for giving notice of injury begins to run when the IW is aware, or by the exercise of reasonable diligence should have been aware, that the condition is causally related to employment, whether or not there is a compensable disability.

Form CA-2

- The front portion of Form CA-2 should be completed by the IW. However, if the IW is incapacitated, this form may be completed by authorized EA official (Agency Reviewer (AR) in ECOMP).

- The IW must indicate when he/she first became aware of the condition (# 11) and also when he/she first realized that it was causally related to his/her employment (#12).

- The back of Form CA-2 also asks when the IW was last exposed to the condition(s) which allegedly caused the condition (#29). This is important because this date, along with the two dates above, may be used to determine if the claim was timely filed.

CA-2 - Agency's Responsibilities

- Review Form CA-2 for completeness.

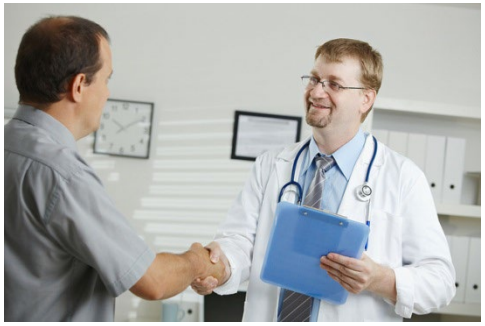
- Verify that IW's home address is correct as noted in Block 7.

- Ensure that the Office of Workers' Compensation Programs (OWCP) Agency Code has been entered correctly in Block 19.

CA-2 - Agency's Responsibilities

- Use the CA-35 checklists as a guide for what information IW should submit and what information EA should submit.
- EAs should submit any agency records regarding IW's exposure to or contact with the agents, substance, noise, etc. which he/she claims caused his/her injury.
- An accurate description of IW's job duties is also helpful.

Basic and Extended Occupational Disease Claims



Basic ODs include conditions such as:

- Orthopedic strains caused by repetitive trauma
- Carpal Tunnel Syndrome
- Tarsal Tunnel and Plantar Fasciitis
- Eye Strain
- Exposure to fumes, dust, smoke (over more than one shift)
  - Second opinions normally not necessary

Extended ODs often require a second opinion to be set up by OWCP and exposure data from EA is also needed:

- Hearing loss
- Asbestosis
- Emotional stress
- Sick building syndrome
- If evidence establishes most of the basic requirements, it may be a *prima facie* case ("first glance") and OWCP may arrange a second opinion.

Form CA-2 Review – Page One

Notice of Occupational Disease and Claim for Compensation **Reset** **Print**

U.S. Department of Labor
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)
1a. Email Address
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 street address, city, state, and ZIP code)
City State ZIP Code
8. Dependents
- Wife, Husband
- Children under 18 years
- Other

Claim Information

9. Employee's occupation
a. Occupation code
10. Location where you worked when disease or illness occurred (include street address, city, state, and ZIP code)
City State 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
OWCP 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 I 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.

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

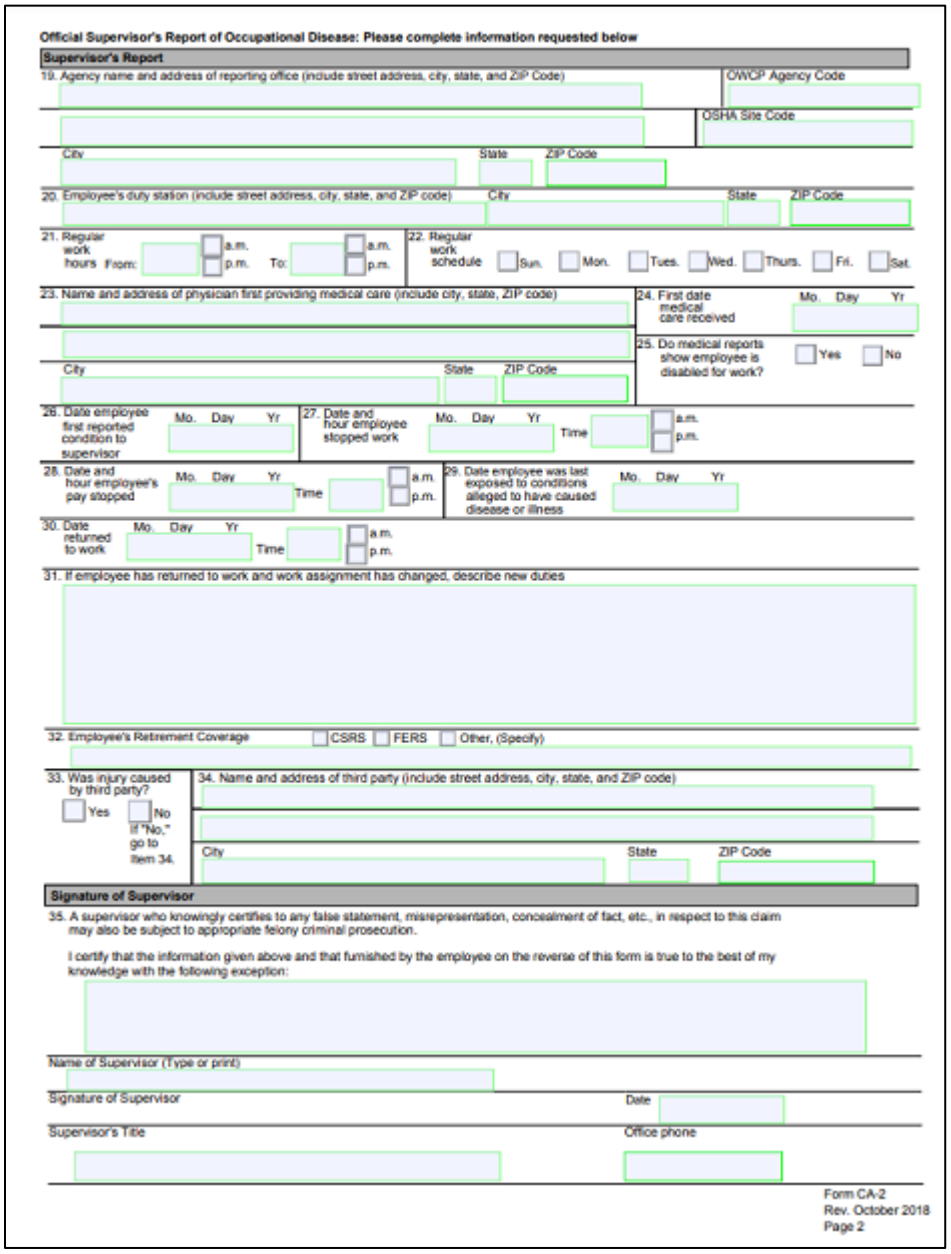
Have your supervisor complete the receipt attached to this form and return it to you for your records.

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 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.

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

Form CA-2 Review – Page Two



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

Supervisor's Report

19. Agency name and address of reporting office (include street address, city, state, and ZIP Code) | OWCP Agency Code | OSHA Site Code

City | State | ZIP Code

20. Employee's duty station (include street address, city, state, and ZIP code) | City | State | ZIP Code

21. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

City | State | ZIP Code

24. First date medical care received Mo. Day Yr

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

26. Date employee first reported condition to supervisor Mo. Day Yr

27. Date and hour employee stopped work Mo. Day Yr Time ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr Time ☐ a.m. ☐ 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 ☐ a.m. ☐ p.m.

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

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

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

City | State | ZIP Code

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

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

Name of Supervisor (Type or print)

Signature of Supervisor | Date

Supervisor's Title | Office phone

Form CA-2
Rev. October 2018
Page 2

Questions

An occupational disease (OD) is defined as a wound or other condition of the body caused by a specific event or series of events or incidents occurring:

a) During one work day or work shift
b) Over more than one work day or work shift

Questions

When providing notice of an occupational disease, the injured worker and employing agency should complete and submit:

a) Form CA-1
b) Form CA-2

Questions

The agency plays an important role in helping injured employees file a Notice of Occupational Disease claim. The agency responsibilities include:

a) Verify that the employee's home address is correct
b) Review the Form CA-2 for completeness
c) Ensure the OWCP Agency Code has been entered correctly
d) Submit any agency record regarding injured worker's exposure to or contact with outside factors that caused their injury
e) All of the above

Take Away Tips

1) An occupational disease (OD) is defined as a wound or other condition of the body caused by a specific event or series of events or incidents over more than one work day or work shift.

2) Form CA-2 should be completed by the injured worker (IW) and an employing agency (EA) supervisor or injury compensation specialist.

3) In a case of latent disability, the time for filing claim does not begin to run until the IW has a compensable disability and is aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship of the compensable disability to his/her employment.

Take Away Tips

4) The IW must indicate when they first became aware of the condition and also when they first realized that it was causally related to their employment. The back of Form CA-2 also asks when the IW was last exposed to the outside factor which allegedly caused the condition. This is important because this date, along with the two dates above, may be used to determine if the claim was timely filed.

5) There are two types of Occupational Disease claims, Basic and Extended. For some Extended OD claims, development may include the need to schedule a second opinion medical examination.