Claim for Compensation

U.S. Department of Labor

Office of Workers' Compensation Programs

SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee — Last: Student's last | First | Middle: middle

b. Mailing Address (*Including City, State, ZIP Code*): Student's home address

E-Mail Address (*Optional*)

OMB No. 1240-0046
Expires: 09/30/2011

c. OWCP File Number: 9-digit OWCP #

d. Date of Injury — Month Day Year: Injury Date

e. Social Security Number: Student's SSN

f. Telephone No./FAX No.: Student's phone

SECTION 2 Compensation is claimed for:

		Inclusive Date Range From	To	Intermittent?	
a.	[X] Leave without pay	Date of sep. return (if applic)		[ ] Yes [X] 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 You must report **all** earnings from employment (**outside** your federal job); include any employment for which you received a salary, wages, income, sales commissions, piecework, or payment of **any** kind during the period(s) claimed in Section 2. Include self-employment, involvement in business enterprises, as well as service with the military forces. Fraudulent concealment of employment or failure to report income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you worked outside your federal job for the period(s) claimed in Section 2?***

[ ] Yes — Name and Address of Business:

[X] 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?

[X] Yes [ ] No — *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)* [ ] 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 [X] 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: Student's signature Date (*Mo., day, year*): LEAVE BLANK

OR center director or HWM as student's authorized rep.

Form CA-7
Rev. June 2005

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 Date: Injury date $ stipend per Grade: Step:	Type $ per	Type $ per	Type $ per
Date Employee Stopped Work: Date Sep. date $ stipend per Grade: Step:	Type $ per	Type $ per	Type $ per

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
WEEK 1 From ____ to ____							
WEEK 2 From ____ to ____							

b. Did employee work in position for 11 months prior to injury? ☐ Yes ☐ No ← Has student been on center 11 mos?

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 Life 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 N/A 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	If intermittent, complete Form CA-7a, Time Analysis Sheet.
Annual Leave	From	To	☐ Yes ☐ No	
Leave without Pay	From Date of sep	To return (if applic.)	☐ Yes ☒ No	If leave buy back, also submit completed Form CA-7b.
Work	From	To	☐ Yes ☐ No	

SECTION 13 Did employee return to work? ☐ Yes ☐ No ← Has student returned from MSWR?

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: Job Corps student

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) center director OR Wellness mgr Title Date Leave blank

Name of Agency Job Corps centername

Date Claim Form Recieved from Employee / /

If OWCP needs specific pay information, the person who should be contacted is: ← who @ center can provide this info?

Name Title

Telephone No. Fax No. E-Mail Address