Attending Physician's Report

Reset Print

U.S. Department of Labor

Office of Workers' Compensation Programs

Record of Examinaton

1. Patient's name Last	First	Middle	2. Date of Injury mo, day yr.	3. OWCP File Number	OMB No. 1240-0046 Expires: XX/XX/XXXX

4. What history of the employment injury (including disease) did the patient give to you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No

ICD Code(s)

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your specific diagnosis(es) related to the employment activity?

ICD Code(s)

8. Do you believe the condition(s) found was caused or aggravated by an employment activity as described in item 4.? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item # 13 ☐ Yes ☐ No	10. Date of admission mo, day yr.	11. Date of discharge mo, day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment: mo. day yr.	mo. day yr.	mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.		18. Period of Partial Disability From mo. day yr. Thru mo. day yr.		19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)

24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:

Name

Specialty

Address

27. What was the reason for this referral? ☐ Consultation ☐ Treatment

City State ZIP

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to criminal prosecution.

Signature of Physician _____ Date

29. Name of Physician	30. Tax ID Number
Address	31. Do you specialize? ☐ Yes ☐ No
City State ZIP	32. If yes, indicate specialty

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. See form instructions for Requests for Accommodations or Auxiliary Aids and Services.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

Office of Workers' Compensation Programs
Division of Federal Employees', Longshore and Harbor Workers' Compensation
Federal Employees' Compensation Act
(OWCP/DFELHWC-FECA)
PO Box 8311
London, KY 40742-8311

IMPORTANT: A medical report is required by the Office of Workers' Compensation Programs before payment of compensation for loss of wages or permanent disability can be made to the employee.

This information is required to obtain or retain a benefit (5 U.S.C. 8101, et seq.). If you have submitted a narrative medical report or a form CA-16 to OWCP within the past 10 days, you need not submit this form CA-20.

OWCP requires that medical bills, other than hospital bills, be submitted on the American Medical Association health insurance claim form, HCFA 1500/OWCP-1500.

INSTRUCTIONS FOR THE INJURED WORKER/ EMPLOYING AGENCY

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20 and complete items 1-3 on the front. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.404). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Association Guides to the Evaluation of Permanent Impairment.

Notice

Requests for Accommodations or Auxiliary Aids and Services

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are here by notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U. S .Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/ administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not send the completed form to this office.