



**Record of Examination**

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) <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No
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25. Remarks  
 \_\_\_\_\_

26. If you have referred the employee to another physician provide the following: Name _____ Address _____ City _____ State _____ ZIP _____	Specialty _____  27. What was the reason for this referral? <input type="checkbox"/> Consultation <input type="checkbox"/> Treatment
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**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 _____ Address _____ City _____ State _____ ZIP _____	30. Tax ID Number _____ 31. Do you specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No 32. If yes, indicate specialty _____
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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.