OMB No. XXXX
Expires: XX/XX/XXXX

Attending Physician's Report

Reset Print

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

1. Patient's name (last, first, middle):	2. OWCP File No. (*if available*):	3. Date of Initial Treatment:	4. Date of this Examination:

5. How did the patient's injury occur?

6. Objective Findings (Include physical examination findings and diagnostic test results). Please also discuss pre-existing condition(s) in the affected body part(s), if any:

7. Medical Diagnosis(es): Please note that "pain" is not a compensable diagnosis; you may however note pain in box 6 above as a symptom of a specific diagnosis or diagnoses.	8. ICD Code(s):

9. Do you believe the condition(s) found was caused or aggravated in any way by an employment activity as described in box 5?
Please note that there is no apportionment under the FECA. Any contribution from work factors is compensable. However, you must explain how the work activity or workplace incident was sufficient to have caused or aggravated the diagnosed conditions for your response to be accepted.

10. Please circle the patient's current disability status: ☐ Totally Disabled ☐ Partially Disabled ☐ Not Disabled

If Totally Disabled. Date disability commenced: Date of anticipated return to full or modified work:

If Partially Disabled. Also, complete Box 11. Date disability commenced: Date of anticipated return to full duty work

If Not Disabled. Was there any disability in the case? If so, indicate dates of disability: From to

11. If the patient is partially disabled, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. You may also complete Form OWCP-5c, Work Capacity Evaluation, which can be found at https://www.dol.gov/sites/dolgov/files/owcp/dfec/regs/compliance/owcp-5c.pdf

12. Remarks:

Signature

13. 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 Treating Provider: _____ Date
If treating provider is not a physician (i.e. nurse, physician's assistant), a co-signature from a physician is required below)

Signature of Physician: _____ Date

14. Name of Physician:	15. Tax ID Number

Address:	City	State	ZIP:	16. Do you specialize? ☐ Yes ☐ No	17. If yes, indicate specialty:

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING FORM CA-20, ATTENDING PHYSICIAN'S REPORT

Box 1 — Enter the patient's full name

Box 2 — If not prepopulated, enter the OWCP File Number provided to you by the patient. If unknown, leave blank.

Box 3 — Enter the first known date this patient sought treatment for the work injury.

Box 4 — Enter the date of this examination (i.e. the examination upon which your findings on the form are based).

Box 5 — Provide an explanation as to how the patient's injury or disease occurred. Be as specific as possible.

Box 6 — Detail the patient's objective findings on physical examination as related to the work injury noted in Box 5. Include results of any diagnostic testing performed. Also, please reference any pre-existing injury or condition to the body part(s) affected by the work injury.

Box 7 — Provide specific diagnoses of each medical condition connected to the work injury. Please note that “pain” is not a compensable diagnosis under the FECA.

Box 8 — Provide corresponding ICD codes for each medical condition noted in Box 7.

Box 9 — Address whether the work injury noted in Box 5 is causally connected in any way to the diagnoses in Box 7. Your answer must be fully explained to be accepted by OWCP. **Note that there is no apportionment under the FECA and any contribution from work factors is compensable.** Types of causal relationship under the FECA include:

Direct Causation. This type of relationship occurs when the injury or factors of employment, through a natural and unbroken sequence, result in the condition claimed.

Aggravation. This type of relationship occurs if a pre-existing condition is worsened, either temporarily or permanently, by the injury or factors of employment. If you believe the work injury aggravated a pre-existing condition, please indicate whether such aggravation is temporary or permanent and if temporary, when the aggravation ceased or is expected to cease.

Acceleration. An employment-related injury or illness may hasten the development of an underlying condition, and acceleration is said to occur when the ordinary course of the disease does not account for the speed with which a condition develops.

Precipitation. A latent condition which would not have become manifest but for the employment is said to have been precipitated by the injury/factors of the employment.

You may also include any consequential conditions that resulted from the initial work injury or disease. Under the FECA, a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.

Box 10 — Indicate the patient's current disability status:

Totally disabled: The claimant is unable to perform any and all work. Provide the date disability commenced and the date of anticipated return to regular or modified work.

Partially disabled, The claimant is incapable of performing the job held when injured, but is capable of some work. Provide the date disability commenced and the date of anticipated return to regular duty work.

Not disabled: The claimant is capable of performing the job held when injured. Indicate any previous dates of disability.

Box 11 — If you stated the patient was partially disabled in Box 10, please indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. A link is provided to Form OWCP-5c, Work Capacity Evaluation, for orthopedic conditions if you would prefer to provide work capacity information separately. The OWCP website at https://www.dol.gov/agencies/owcp/FECA/regs/compliance/forms also has work capacity evaluation forms for psychiatric (OWCP-5a) and cardiac (OWCP-5b) conditions if needed.

Box 12 — If you have any additional remarks regarding this patient's work injury, please provide here. If not, leave blank.

Box 13 Please sign and date the form. If you are not a physician, a physician must co-sign and date the form as well. Under the FECA, medical evidence must be submitted by a qualified physician. Nurse practitioners and physician assistants are not considered qualified physicians under the FECA unless the medical report is countersigned by a physician. A “physician” includes clinical psychologists acting within the scope of their practice. Also, under the FECA, a “physician” includes chiropractors only if there is a diagnosed spinal subluxation and it is demonstrated by x-ray.

Box 14-17 Please provide the name, address and tax identification number of the physician signing the form. If the physician is Board-certified in a particular specialty, please indicate such and provide the specific specialty in Box 17.

Please send the completed form and 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

NOTE - To expedite the processing of this patient's claim, you can concurrently upload this form directly into their case file using the Employees' Compensation Operations and Management Portal (ECOMP). You can access ECOMP from any internet browser at:

https://www.ecomp.dol.gov/

When you access the website, choose the "Upload Document" option. You will be asked to provide the patient's case number, last name, date of birth and date of injury to upload a document. ECOMP will then provide you with a Tracking Number so that you can verify when OWCP has received the CA-20. For more detailed information about this document submission feature, visit the ECOMP website and click "Help."

Important Notes:

A medical report is required by OWCP 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.).

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

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 the 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 hereby 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 XX. Note: Please do not send the completed form to this office.