

About Form CA-7

[File a CA-7](#)

When should I file?

- If you have an OWCP case number and have sustained wage loss, you should file a Form **CA-7** to claim compensation for periods of disability or time lost due to medical appointments and treatment.
- If wage loss continues, beyond the initial claim for compensation, you should submit subsequent **CA-7** forms each two weeks.
- You may also file a claim for a Schedule Award using form **CA-7**.

What do I need?

- You only need an OWCP case number in order to file a **CA-7**.
- If you filed your initial claim (**CA-1** or **CA-2**) through ECOMP, you can access that case via your Employee Dashboard in ECOMP.
- If you did not file your initial claim through ECOMP, you can locate an existing case from your Employee Dashboard by choosing the option to "Start a new **CA-7** based on a case not listed here."
- **Note** - You must submit medical evidence to support disability for any period claimed. You can upload any supporting documentation, including this medical evidence, while filing the **CA-7** or at any time thereafter via ECOMP.

Are other forms needed?

- If you file a Form **CA-7** for intermittent hours or days, you should also complete form **CA-7a (Time Analysis Form)**. This can be done through ECOMP.
- If you are claiming leave buy back, Form **CA-7b (Leave Buy Back Worksheet/Certification and Election)** will also be needed. Your employing agency can assist with filing this form. **NOTE** - You cannot file a Form **CA-7b** through ECOMP. You can however, find the **CA-7b** on DFEC's website. Once completed, the document can be uploaded to your OWCP case through ECOMP's electronic document submission feature and associated with a **CA-7** submitted through ECOMP.

How do I file the form?

The process for filing a form involves completing several form sections made up of smaller form-filing steps. These individual steps can be viewed in the navigation bar on the left. Unless otherwise noted, all of the fields in the form must be completed. The form may be saved at any time, and completed later. Once the form has been submitted, it will be reviewed by the employee's supervisor and/or the Agency Reviewer before submission to OWCP.

OMB No. 1240-0046 (Expires: 10-31-2014) Privacy Act and Public Burden Statements

The Office of Management and Budget (OMB) control number displayed on this data collection instrument has an expiration date of 10/31/2014; however, in accordance with the requirements of the Paperwork Reduction Act (44 U.S.C. 3501), the Department has submitted a request to the OMB to extend this expiration date for another three years. Therefore, pursuant to 5 C.F.R. § 1320.10 (e)(2), the Department is authorized to continue collecting this information after the displayed expiration date so long as it remains under review at the OMB. Once the OMB takes action on the aforementioned extension request, the new expiration date will be displayed on the data collection instrument.

[File a CA-7](#)

Base Claim for Compensation upon Existing Case Number

Your CA-7 will be based upon this case.

 Case 252169726 ECN 2487018	CA-1	Case created by DFEC	
Employee	Tom Smith	Date of event	02/01/2016
Organization	OWCP TEST ONLY	Initiated	04/14/2016

Not the right case?

[Locate a different case](#)

Continue

ECOMP Claim for Compensation (CA-7)

New Form

Draft

Step 1A

Claimant Basics

Continue

Please fill out the basic information below. Some of the fields have been filled in for you from the information already contained in your OWCP case file. If corrections are needed, please update the appropriate fields.

1a Employee name (first, middle, last) TOM SMITH

1b Mailing address 123 E ST Non-US address
City WASHINGTON State DC - District Of Zip code 20210

1c OWCP File Number 252169726

1d Date of injury 02/01/2016

1e Social security number ***** Confirm SSN ***** Claimant is not a US citizen, and does not have a Social Security Number.

1f Telephone number 2025551234 International

Who should review this form?

Employee's supervisor will review this form Agency Reviewer will review this form

Immediate supervisor's email @ ?

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 CA-7 X
Draft

Step 1B Compensation Claimed

Back

Continue

Compensation is claimed for:

Leave without pay

From 05/01/2016 To 05/10/2016 Intermittent

Leave buy back

From MM/DD/YYYY To MM/DD/YYYY Intermittent

Other wage loss (Specify type such as downgrade, loss of night differential, etc.)

Type

From MM/DD/YYYY To MM/DD/YYYY Intermittent

Back

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 CA-7 X

Draft

Step 1C Non-Federal Employment

Back

Continue

You must report any and all earnings from employment (outside your federal job); include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing 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? Refer to the Instructions which provide further clarification.

3 Have you worked outside your federal job for period(s) claimed on Step 2B? Yes No

Name of business

Address

Example: 123 Pleasant Lane, apt. A

Non-US address

City Example: Fairview

State

Zip code

Dates worked

From MM/DD/YYYY



To MM/DD/YYYY



Type of work

Back

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 CA-7 X

Draft

Step 1D First Claim for Injury

Back

Continue

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 No

Steps E and F have been enabled in the navigator at left. After filing this form you should also file new Form SF-1199A, "Direct Deposit Sign-up."

Back

Continue

Step 1E Dependents

Back

Continue

List your dependents (including spouse)

1

Name of dependent #1

Social Security # Repeat SSN

Date of birth Relationship

Is this dependent living with you? Yes No

2

Name of dependent #2

Social Security # Repeat SSN

Date of birth Relationship

Is this dependent living with you? Yes No

5a Are you making support payments for a dependent shown above? Yes No

If yes, support payments are made to:

Name

Address Non-US address

City State Zip code

5b Were support payments ordered by a court? Yes No

Back

Continue

Step 1F Other Claims & Benefits

Back Continue

6a Was/Will there be a claim made against a third party? Yes No

6b Have you ever applied for or received benefits from the Department of Veterans Affairs? Yes No

Claim number

Full Address of VA Office Where Claim Filed Non-US address

City State Zip code

Nature of disability

Amount of monthly payment

6c Have you ever 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 Other

Back Continue

Step 2 Attachments

Back

Continue


You can attach supporting documents here. This includes a Form SF-1199A (Direct Deposit Form) as noted in Step 2D or a court order for any dependent listed in Step 2E. If you don't have the documents now, you submit them later.

 [Click to attach a new document](#)

0 documents uploaded so far

 Attach New Document...

Delete selected attachment

 Have Questions?
[View Frequently Asked Questions.](#)

Back

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726

CA-7



Draft

Step 3

Review

Back

Continue

Review this information carefully before continuing.

Employee name (first, middle, last) TOM SMITH

XX ECOMP TEST (DO NOT USE)

Government organization

OWCP TEST ONLY
C/O ECOMP -TA TEST
203 UNION STREET
WASHINGTON, DC 20210

Reviewer

Agency Reviewer

Home mailing address

123 E ST WASHINGTON DC 20210

OWCP File Number

252169726

Date of injury

02/01/2016

Social security number

*****3333

Home telephone

2025551234

Compensation claimed

Leave without pay 05/01/2016 To 05/10/2016

Non-federal employment?

No

First-time claim?

No

Changes to dependents?

Yes

Dependent #1

SO

Lives with claimant.

Dependent #2

Are you making support payments for a dependent shown above?

No

Third party claim

No, there will not be a claim made against a 3rd party.

No, I have not applied for nor received benefits from the Department of Veterans Affairs.

Claim #

VA disability benefits

ECOMP Claim for Compensation (CA-7) Case 252169726 CA-7 Draft

Step 4 **Sign & File Form** Back Sign & File Form

Submitting this form is considered the same as signing it.

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.

Back Sign & File Form

ECOMP Claim for Compensation (CA-7) Case 252169726 CA-7 Draft

Step 4 **Sign & File Form** Back Sign & File Form

Submitting this form is considered the same as signing it.

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.

I understand that 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. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.

I Agree Cancel Sign & File Form

This form has been forwarded for review

Case 252169726 ECN 2584992		CA-7	Pending review by FECA Agency Reviewer	
Employee	TOM SMITH	Date of event	02/01/2016	
Organization	OWCP TEST ONLY	Initiated	05/25/2016	
Form Locked	View	Get PDF	Upload Attachments	More...

Wait! You are not finished yet

In order to complete this process, this form MUST be

- 1) Printed
- 2) Signed by all parties
- 3) Retained by the Agency with all original signatures
- 4) Made available for inspection by OWCP/DFEC, if and when necessary.

Although the signed copies of such forms are physically maintained by the Employing Agency, they remain covered by the government-wide Privacy Act system of records entitled DOL/GOVT-1.

[Continue to Review this Form](#)

[Done](#)

Step 1 Claim Summary

Claimant: SMITH, TOM
DOB: 05/01/1965
SSN: *****3333
Address: 123 E ST
WASHINGTON , DC 20210

ECN: 2584992
Date of event: 02/01/2016
Filed: 05/25/2016
Agency: OWCP TEST ONLY

 [Click to attach a new document](#)

There are currently 0 attachments for this form.

 Attach New Document...

Delete selected attachment

? Have Questions?
[View Frequently Asked Questions.](#)

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 X

Pending review by FECA Agency Reviewer

Step 2

Review CA-7 Claimant Part

Back

Continue

Employee name (first, middle, last) TOM SMITH

XX ECOMP TEST (DO NOT USE)

Government organization

OWCP TEST ONLY
C/O ECOMP -TA TEST
203 UNION STREET
WASHINGTON, DC 20210

Reviewer

Agency Reviewer

Home mailing address

123 E ST WASHINGTON DC 20210

OWCP File Number

252169726

Date of injury

02/01/2016

Social security number

*****3333

Home telephone

2025551234

Compensation claimed

Leave without pay 05/01/2016 To 05/10/2016

Non-federal employment?

No

First-time claim?

No

Changes to dependents?

Yes

Dependent #1

SO

Lives with claimant.

Dependent #2

Are you making support payments for a dependent shown above?

No

Third party claim

No, there will not be a claim made against a 3rd party.

VA disability benefits

No, I have not applied for nor received benefits from the Department of Veterans Affairs.

Claim #

/month

Step 3A Pay Rate

Back

Continue

Has a CA-7 been filed for this claim before? Yes No

Enter employee pay information in section 8 below.

Do you have updated pay information about this claimant? Yes No

8 Pay rate as of date of injury (02/01/2016, Grade: 9, Step: 5)

Base pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>

Pay rate as of date the employee stopped work (MM/DD/YYYY , Grade: 9, Step: 5)

Base pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>
Additional pay	<input type="text"/>	per	<input type="text"/>

Back

Continue

If the employee works a fixed 40-hour per week schedule, indicate which days of the week they work. If not, enter details for the two week pay period in which work stopped. Indicate the date for the Sunday starting the two week pay period, then enter hours for each day in that period and the stop work date. Finally indicate if the employee held this same position for the past 11 months.

9a Does employee work a fixed 40-hour per week schedule? Yes No

1 Select scheduled days Sun Mon Tue Wed Thu Fri Sat

2 What is the date for the Sunday on which this two week pay period begins?

Show scheduled hours for the two week pay period in which work stopped.

	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Week 1							
Week 2							

On what date did employee stop work?

9b Did employee work in position for 11 months prior to injury? Yes No

If no, would position have afforded employment for 11 months but for the injury? Yes No

Step 3C

Benefits and COP

Back

Continue

10 On date pay stopped, was the employee enrolled in:

a) Health benefits under FEHBP or PSHB

HB Code

c) Optional Life Insurance

Class (D-Z only)

b) Basic Life Insurance

d) A Retirement System

11 Continuation of pay (COP) received (select inclusive dates)

From MM/DD/YYYY



To MM/DD/YYYY



Intermittent

Back

Continue

Step 3D

Pay, Return to Work

Back

Continue

12 Show pay status inclusive dates for the period(s) claimed

Sick leave	From	<input type="text" value="MM/DD/YYYY"/>	To	<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/> Intermittent
Annual leave	From	<input type="text" value="MM/DD/YYYY"/>	To	<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/> Intermittent
Leave without pay (LWOP)	From	<input type="text" value="MM/DD/YYYY"/>	To	<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/> Intermittent
Work	From	<input type="text" value="MM/DD/YYYY"/>	To	<input type="text" value="MM/DD/YYYY"/>	<input type="checkbox"/> Intermittent

13 Did employee return to work? Yes No

What date did he/she return to work?

If returned to work, did employee return to the pre-date-of-injury job, with the same hours and the same duties?

Yes No

14 Remarks

15 Agency official name

Agency official title

Date Claim Form Received from Employee 05/25/2016

Name of Agency C/O ECOMP -TA TEST
OWCP TEST ONLY
ECOMP Testing Only (DO NOT USE)
XX ECOMP TEST (DO NOT USE)

If OWCP needs specific pay information, the person who should be contacted is

Name

Email Title

Telephone International Fax International

Step 4

Attachments

Back

Continue


You can submit additional documentation associated with this claim by uploading the document(s) here.

 [Click to attach a new document](#)

There are currently 0 attachments for this form.

 [Attach New Document...](#)

Delete selected attachment

 Have Questions?
[View Frequently Asked Questions.](#)

Back

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 X

Pending review by FECA Agency Reviewer

Step 5

Review

Back

Continue

Has a CA-7 been filed for this claim before? No

Do you have updated pay information about this claimant?

Date of injury 02/01/2016

Pay rate as of date of injury \$20 per Hour

Additional pay 1 per

Additional pay 2 per

Additional pay 3 per

Date stopped work 05/01/2016

Pay rate as of date the employee stopped work \$25 per Hour

Additional pay 1 per

Additional pay 2 per

Additional pay 3 per

Fixed 40-hour per week schedule Yes

Scheduled days Mon Tue Wed Thu Fri

Sunday on which this period begins

Week 1 hours

Week 2 hours

Date employee stopped work

Did employee work in position for 11 months prior to injury? Yes

If no, would position have afforded employment for 11 months but for the injury?

Health benefits under FEHBP No (Code)

Optional Life Insurance No (Class)

Basic Life Insurance No

Retirement System No (Plan)

Continuation of pay (COP) received To

ECOMP Claim for Compensation (CA-7) | Case 252169726 | ECN 2584992 | CA-7 | Pending review by FECA Agency Reviewer

Step 6 Sign & Forward

Action to take

Sign & Forward or File
I certify that the information provided in this form, and that furnished by the employee in this form, is true to the best of my knowledge, with any exceptions noted in Section 14 (Remarks).


Request Resubmission
Why?

Back Sign & Forward

ECOMP Claim for Compensation (CA-7) | Case 252169726 | ECN 2584992 | CA-7 | Pending review by FECA Agency Reviewer

Step 6 Sign & Forward

Action to take

 I understand that an employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may be subject to appropriate felony criminal prosecution.

I Agree Cancel

ECOMP Claim for Compensation (CA-7)

 **Case 252169726** | ECN 2584992 **CA-7** ✕

Pending final review by FECA Agency Reviewer

This form has been forwarded for review

 **Case 252169726** | ECN 2584992 **CA-7** Pending final review by FECA Agency Reviewer

Employee	TOM SMITH	Date of event	02/01/2016
Organization	OWCP TEST ONLY	Initiated	05/25/2016

[🔒 Form Locked](#) | [👁 View](#) | [📄 Get PDF](#) | [📎 Upload Attachments](#) | [⌵ More...](#)

➔ A digital copy of this form will be kept by ECOMP for 5 years. (Public Law 91-596 and 29 CFR 1904)

**Continue to Review
this Form**

Done

Step 1 Claim Summary

Claimant: SMITH, TOM
DOB: 05/01/1965
SSN: *****3333
Address: 123 E ST
WASHINGTON , DC 20210


ECN: 2584992
Date of event: 02/01/2016
Filed: 05/25/2016
Supervisor: [REDACTED]
Agency: OWCP TEST ONLY

 [Click to attach a new document](#)

There are currently 0 attachments for this form.

 [Attach New Document...](#)

Delete selected attachment

 Have Questions?
[View Frequently Asked Questions.](#)

Continue

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 X

Pending final review by FECA Agency Reviewer

Step 2A

Claimant Portion

Back

Continue

Employee name (first, middle, last) TOM SMITH
Government organization XX ECOMP TEST (DO NOT USE)
OWCP TEST ONLY
C/O ECOMP -TA TEST
203 UNION STREET
WASHINGTON, DC 20210
Reviewer Agency Reviewer

Home mailing address 123 E ST WASHINGTON DC 20210
OWCP File Number 252169726
Date of injury 02/01/2016
Social security number *****3333
Home telephone 2025551234

Compensation claimed Leave without pay 05/01/2016 To 05/10/2016

Non-federal employment? No
First-time claim? No
Changes to dependents? Yes

Dependent #1 SO
Lives with claimant.

Dependent #2

Are you making support payments for a dependent shown above? No

Third party claim No, there will not be a claim made against a 3rd party.

VA disability benefits No, I have not applied for nor received benefits from the Department of Veterans Affairs.

Claim #

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 X

Pending final review by FECA Agency Reviewer

Step 2B

Supervisor Portion

Back

Continue

Has a CA-7 been filed for this claim before? No

Do you have updated pay information about this claimant?

Date of injury 02/01/2016

Pay rate as of date of injury \$20 per Hour

Additional pay 1 per

Additional pay 2 per

Additional pay 3 per

Date stopped work 05/01/2016

Pay rate as of date the employee stopped work \$25 per Hour

Additional pay 1 per

Additional pay 2 per

Additional pay 3 per

Fixed 40-hour per week schedule Yes

Scheduled days Mon Tue Wed Thu Fri

Sunday on which this period begins

Week 1 hours

Week 2 hours

Date employee stopped work

Did employee work in position for 11 months prior to injury? Yes

If no, would position have afforded employment for 11 months but for the injury?

Health benefits under FEHBP No (Code)

Optional Life Insurance No (Class)

Basic Life Insurance No

Retirement System No (Plan)

Continuation of pay (COP) received To

ECOMP Claim for Compensation (CA-7)

Case 252169726 | ECN 2584992 CA-7 X

Pending final review by FECA Agency Reviewer

Step 3

Sign

Back



Submit

I understand that an employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may be subject to appropriate felony criminal prosecution.

Action to take

Sign & Forward or File

Request resubmission

Why?

Back



Submit

This form has been submitted to DFEC

Case 252169726 ECN 2584992		CA-7	Submitted to DFEC
Employee	TOM SMITH	Date of event	02/01/2016
Organization	OWCP TEST ONLY	Initiated	05/25/2016
Form Locked	View	Get PDF	Upload Attachments More...

Wait! You are not finished yet

In order to complete this process, this form MUST be

- 1) Printed
- 2) Signed by all parties
- 3) Retained by the Agency with all original signatures
- 4) Made available for inspection by OWCP/DFEC, if and when necessary.

Although the signed copies of such forms are physically maintained by the Employing Agency, they remain covered by the government-wide Privacy Act system of records entitled DOL/GOVT-1.

I Agree. Get PDF and Save / Print

Done