Notice of Recurrence

Reset Print

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

Employee: Complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0009
Expires: 01/31/2024

Part A - Employee

1. Name of employee (Last, First, Middle Initial)	2. Social Security Number	3. OWCP file number for original injury

4. Date of Birth Mo./Day/Yr.	5. Sex ☐ Male ☐ Female	6. Home telephone

7. Home mailing address (include street address, city, state, and ZIP code). See instructions for address requirement.

City _____ State _____ Zip Code _____

8. Dependents
- ☐ Spouse
- ☐ Child/Children under 18 years
- ☐ Other, e.g., qualifying student under age 23

9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)

10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.

11. Date and Hour of original injury (Mo./Day/Yr.)	12. Date and Hour of recurrence (Mo./Day/Yr.)	13. Date and Hour stopped work after recurrence (Mo./Day/Yr.)	14. Date and Hour pay stopped after recurrence (Mo./Day/Yr.)	15. Date and Hour returned to work (Mo./Day/Yr.)

16. Are you claiming? Check both if applicable.
- ☐ Medical Treatment
- ☐ Time Loss From Work

17. Date of first medical treatment following recurrence (Mo./Day/Yr.)

18. Name and address of treating physician

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) ◯ Yes ◯ No

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records.

I hereby claim medical treatment if needed and **up to 45 days** Continuation of Pay if disabled from work.

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 criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, I authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative).This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

23. Signature of employee	24. Date (Mo./Day/Yr.)

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.

Part B - Federal Employing Agency

25. Name and address of reporting office (include street address, city, state and ZIP Code) | OWCP Agency Code

City | State | Zip | OSHA Site Code

26. Employee's duty station (include street address, city, state, and ZIP Code) | 27. Date of first return to FULL-TIME REGULAR duty following original injury Mo./Day/Yr.

City | State | Zip

28. Regular work hours From: To:

29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

30. Date of injury Mo./Day/Yr.

31. Date of recurrence Mo./Day/Yr.

32. Date stopped work after recurrence Mo./Day/Yr. Time:

33. Date pay stopped after recurrence Mo./Day/Yr.

34. Dates COP paid for recurrence Mo./Day/Yr. From: To:

35. Date returned to work after recurrence Mo./Day/Yr. Time:

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ◯ Yes ◯ No

37. At the time of the injury did your agency authorize medical treatment on Form CA-16? ◯ Yes ◯ No

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation?

◯ Yes ◯ No If so, provide full details.

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.

40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

A supervisor or compensation specialist who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate criminal prosecution.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)	42. Title	43. Work phone	44. Date (Mo./Day/Yr.)

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

   $ _____ per _____

5. Do you claim compensation for lost wages? ◯ Yes ◯ No

   If so, for what period? _____ through _____

6. Have you received any pay during the period claimed? ◯ Yes ◯ No

   If so, how much and from what source? _____ _____

7. Signature of Employee	8. Date (Mo./Day/Yr.)

INSTRUCTIONS FOR COMPLETING FORM CA-2a NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work-related injury or condition. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties. See 20 C.F.R. 10.5 (x).

IF A NEW INJURY OR CONDITION DUE TO OCCUPATIONAL EXPOSURE OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details. Please ensure you provide your current address at the time of your claimed recurrence. The address is to include: the House Number and Street Name, City/Town, State, and Zip Code.

  For the FECA program to effectuate proper claims management, a FECA claimant is expected to provide the home address where he or she resides. A Post Office (PO) Box or attorney/representative address does not suffice for this purpose.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment; history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. **The physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original Injury.** Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations.
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless: the claimant is still receiving continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting neither wage-loss compensation nor payment of medical expenses. In these instances, file the form in the Employee Medical Folder.
- If COP is being paid, obtain medical evidence using Form CA-17, "Duty Status Report", as often as circumstances indicate.
- **For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.**

Privacy Act

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 health care 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.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 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. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs,U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

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, DFEC, in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the FECA 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 your OWCP claims examiner to ask about this assistance.