



# Welcome to ECOMP

## The Employees' Compensation Operations & Management Portal

### Terms of Use

You are accessing a U.S. Government information system that is owned and operated by the Department of Labor. The Department of Labor information systems are provided for the processing of official U.S. Government information only, and are therefore, owned by the Department of Labor. Authorized users are responsible for the proper handling of information they access.

USE OF THIS SYSTEM BY ANY USER AUTHORIZED OR UNAUTHORIZED CONSTITUTES A CONSENT TO ACTIVITY MONITORING, RECORDING, DISCLOSURE, AND ACCEPTS THAT USE OF THE SYSTEM IS SUBJECT TO AUDIT BY AUTHORIZED PERSONNEL.

Fraud and related activity in connection with computers is prohibited by Title 18, U.S. Code Section 1030. Furthermore, this law states that intentionally accessing a computer without authorization or exceeding authorized access and thereby obtaining information from any department or agency of the United States is prohibited and subject to civil and criminal penalties, including (but not limited to), punishment by fine and/or imprisonment. Additionally, DOL may provide law enforcement with any potential evidence of a crime found on aforementioned systems in order for them to investigate such offenses.

### Have you been hurt on the job?

If you are a Federal Employee or a Contractor and have sustained a work-related injury or illness, use ECOMP to report the incident to your supervisor.

If you are a Federal Employee you may also file a claim for benefits under the Federal Employees' Compensation Act (FECA). Depending upon your agency, start by filing OSHA's Form 301, then file a claim using either form CA-1 (for traumatic injury) or form CA-2 (for occupational disease). After you have received an official FECA case number, you may also file form CA-7 (Claim for Compensation).

### Need to upload a document?

Stakeholders and interested parties can use ECOMP to upload documents to active FECA cases. You can upload letters, medical reports and other supporting documentation. You will need the official FECA Case Number and other identifying information to use this feature.

[UPLOAD DOCUMENTS](#)

### Medical Providers:

- Only medical reports can be submitted in ECOMP.

Do not upload bills in ECOMP as they will not be processed.

- Easily submit medical bills and reports in one electronic transaction using our **free** Direct Data Entry or Secure FTP. Refer to this [Quick Guide](#) for detailed steps. Learn all your options by clicking [here](#).

### Looking for a Pharmacy?

Click [here](#) to locate an in-network pharmacy in your area.

### Need to file a form?

Register for an account or sign in to get started!

#### Sign In

Email or Username

Password

[SIGN IN](#)

[Forgot password?](#)

Need an account? [Register](#)

Track status of form or document

Enter ECN or DCN

[TRACK STATUS](#)



## REGISTER FOR ECOMP

Registration Help

Your ECOMP account enables you to file and manage forms with the U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP). Your account is covered under the [Privacy Act](#). If you already have an account, [sign in here](#).

### ACCOUNT BASICS

First Name	Middle Name (optional)	Last Name
------------	------------------------	-----------

Mobile Telephone	<input type="checkbox"/> International
------------------	--

Email Address
---------------

Date of Birth	
(mm)	(dd) (yyyy)

Address
---------

City	State
------	-------

ZIP code	Country UNITED STATES OF AMERICA
----------	-------------------------------------

Social Security Number	Confirm SSN
------------------------	-------------

<input type="checkbox"/> I do <b>NOT</b> have a Social Security Number and I am <b>NOT</b> a US Citizen.
--



### Complete the Registration

### Recommendations:

- Give your mobile number
- Use your personal email address, which will still be active, even after you graduate
- Use your home-of-record, or parents, or other mailing address that guarantees you will receive any email that the DOL sends to you...even a year from now; not your temporary college living address.

CANCEL

CREATE ACCOUNT



## YOU'RE ALMOST DONE

An email has been sent to this email address:

**Check your email and follow the instructions inside.**

If you do not receive your confirmation email in 10 minutes, it may have been lost.

1. Check your spam folder.
2. Ensure that your email service is not blocking emails from [www.ecomp.dol.gov](mailto:www.ecomp.dol.gov)
3. Make sure that the email you gave us is your correct address (if not please re-register).

Watch for your confirming email and follow its instructions.

## Rules of Behavior

BEFORE USING THIS U.S. FEDERAL GOVERNMENT SYSTEM, YOU MUST READ AND AGREE TO THE FOLLOWING RULES OF BEHAVIOR.

### Restricted User:

- This system houses United States Department of Labor sensitive information covered by the Privacy Act of 1974 that shall be accessed and used only for official government business by authorized personnel. Unauthorized access or use of this site (e.g., images, data, text, contents, or any information provided) may subject violators to criminal, civil and/or administrative action. All information on this site may be intercepted, recorded, read, and disclosed by and to authorized personnel for official purposes, including criminal investigations. Access or use of this computer system by any person whether authorized or unauthorized constitutes consent to these terms.

### Accountability:

- Users shall acknowledge actions and accept responsibility for correcting errors and resolving problems.

### Confidentiality:

- Users shall encrypt system data with the latest approved encryption technology when storing or transmitting.
- Users shall protect physical copies from getting lost and not leave printouts unattended.
- Users shall prevent unauthorized people from viewing the information whether on the computer screen or on paper.
- Users shall make sure that they understand their responsibilities under the Privacy Act to protect information that is transmitted through and resides in the system from improper disclosure.

### Integrity:

- Users shall make sure that the information which they manage, and for which they have responsibility, is accurate and up-to-date.
- Users shall prevent unauthorized changes, destruction or tampering with information.
- Users shall create only authorized records.

### Passwords and User IDs:

- Users shall never share passwords or account information.
- Users shall use only the user accounts to which they have been assigned to access the system.
- Users shall protect their accounts by memorizing their passwords and never write them on paper or store them in an electronic file.
- Users shall change their passwords immediately should they suspect that someone else knows their passwords.

### Security:

- Users shall immediately report security vulnerabilities and violations to proper authorities and their employing agency contact.
- Users shall immediately report accidental or intentional disclosure of system information to proper authorities and their employing agency point of contact.
- Users shall log out of the system when finished using the system or leaving their computers.
- Users shall limit sharing of system information only with users who have the need to know, in regard to worker's compensation related business.

### Penalties for Non-compliance:

Users who do not comply with the ROBE are subject to penalties that can be imposed under the Privacy Act and existing policy and regulations, including:

- Suspension of system privileges; and/or
- Criminal prosecution.

OWCP will enforce the use of penalties against any user who willfully violates any OWCP, Department, or Federal system security (and related) policy.

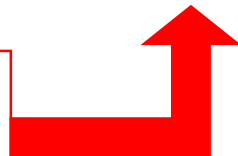
☐ I have read the above document and agree to these Rules of Behavior.



Next



Select  
"Forms"



## Welcome to your ECOMP Dashboard

Because your identity has not yet been verified, your dashboard has limited information and functionality. To access your full dashboard, [click here](#) (if available) and complete your identity verification.

Each injury/illness claim you have initiated can be found in the table below. To file a new injury/illness claim or a CA-7 claim for compensation on an existing injury/illness claim, click on the "Form" link above. Document upload may be accessed in the "Documents" link above.

You have 0 injury/illness claim(s) in Draft status in the table below; by clicking anywhere in the row, you will be taken to its form page where you can continue finalizing it.

The Action Required tab shows if any actions are needed of you to continue your claims process. This will include returned forms; if your Action Required tab is empty there is nothing required of you at this time.

**Forms (0)****Action Required (0)**

Date of Injury



Agency



Status



① Once you verify your identity, you will be able to access the Case Review page for all injury/illness claims where you can:

- View case details including the injury claim information; claim status; compensation payment tracking; compensation payment history; and from within the payment period details you may also access employee data, compensation information, health benefits, life insurance, payee information, and compensation formula information. You can also access additional billing information through the "Bill Pay Inquiry" link. Pharmacy information is available through the "Pharmacy Benefit" link.
- File associated case forms such as a CA-7 Claim for Compensation using the new case claim drop down button.
- Finish filing any injury/illness claims that are in Draft status.



## Which Forms Can I File?

Each agency determines which forms are available for filing through ECOMR. The way you report an incident or file a claim depends on your employment status and your employing agency. To learn which forms you can file, fill out the information below.

### EMPLOYMENT STATUS ⓘ

☒ Federal Employee ☐ Contractor

### GOVERNMENT ORGANIZATION ⓘ

What part of the government were you working for at the time of your injury?

Select Department  
RESERVE OFFICER TRAINING CORPS (ROTC) ✓

Agency Group  
RESERVE OFFICER TRAINING CORPS (ROTC)

Agency  
RESERVE OFFICER TRAINING CORPS (ROTC)

Select Duty Station  
ARMY ROTC CLAIMS, 1240 EAST 9TH STREET, ROOM 851, CLEVELAND, OH 44199 ✓

You can file forms CA-1, CA-2, CA-3, CA-6, CA-7, CA-7a, CA-16 for this organization through ECOMR ⓘ

To file a form for injury or illness:

1. Claim benefits using either form CA-1 (for Traumatic Injury) or form CA-2 (for Occupational Disease). Pending review of your claim, you may receive a FECA Case Number.

2. If you wish to claim compensation and you've received an official FECA Case Number, you can file form CA-7 (Claim for Compensation).  
 ⓘ You must have a FECA Case number to file a CA-7

Select:  
Federal Employee  
Reserve Officer Training Corps  
1240 East 9th ST RM 851 Cleveland  
OH 44199  
CA-1 (Injured) or CA-2 (Illness)  
You will not do a CA-7

## About Forms CA-1 and CA-2

### WHICH FORMS SHOULD I USE?

Form **CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occurring during one work shift.

Form **CA-2 (Notice of Occupational Disease and Claim for Compensation)** is for use by Federal employees to claim benefits under the Federal Employees' Compensation Act for a medical condition resulting from an incident or activity occurring over more than one work shift.

### 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 progress bar at the top of the page.

If you filed an **OSHA-301**, the information you entered in that form will be used to automatically fill in matching fields on the FECA form, but you should edit any of the narrative responses as needed.

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 (if appropriate).

## Select CA-1 or CA-2

There are two types of injury claims that may be filed: **CA-1** or **CA-2**. Only one claim (either Form **CA-1** or Form **CA-2**) may be filed based on a single incident. If your agency requires a Form **OSHA-301** prior to filing a FECA claim, this means that only one FECA claim form may be filed per **OSHA-301**.

Select the appropriate form:

CA-1	For Traumatic Injury
<p>CA-1 - Federal Employee's Notice of Traumatic Injury &amp; Claim for Continuation of Pay/Compensation</p> <p>Use this form if you have sustained a traumatic injury on the job. A traumatic injury is a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift.</p> <p>Examples of a traumatic injury include: a dog bite, a motor vehicle accident or a slip and fall.</p> <p><a href="#">SELECT &amp; CONTINUE</a></p>	

CA-2	For Illness
<p>CA-2 - Notice of Occupational Disease and Claim for Compensation</p> <p>Use this form if you have sustained an occupational disease as a result of your job duties. An occupational disease or illness is a condition produced by the work environment over a period longer than a single workday or shift.</p> <p>Examples of an occupational disease include: noise induced hearing loss, asbestos-related illness or orthopedic injuries due to repetitive motion.</p> <p><a href="#">SELECT &amp; CONTINUE</a></p>	

CA-1 – injury  
CA-2 – illness

## CA-1 Traumatic Injury Claim

ECN | Draft

Welcome to CA-1. The steps in this form are listed in the navigator above. Unless otherwise noted, you must complete all fields. Start by filling out your basic information below.

### EMPLOYEE BASICS

Employee First Name

Middle Name (optional)

Last Name

1

1a Employee Email

Social Security Number

Confirm SSN

2

Date of Birth

3    

Sex

4 ☐ Male ☒ Female

Home Telephone

5  ☐ International

Grade as of Date of Injury

Step as of Date of Injury

6

- Use your mobile number
- Use your personal email address, which will still be active, even after you graduate.
- Use your home-of-record, or parents, or other mailing address that guarantees you will receive any email that the DOL sends to you; not your temporary college living address.

## HOME MAILING ADDRESS

Address

City

State

ZIP code

Country

## DEPENDENTS

☐ Wife, Husband

☐ Children Under 18 Years

☐ Other

☒ None

## WHO SHOULD REVIEW THIS FORM?

Immediate Supervisor's Email

Select Email Domain

Autosaved



EXIT



Left inactive long enough, ECOMP will timeout, dumping your entries. Click "Autosaved" frequently to save your data.



## CA-1 Traumatic Injury Claim

ECN | Draft

Describe the details of employee's injury.

### DESCRIPTION OF INJURY

Place where event occurred

1

Address

City

State

ZIP code

Country

UNITED STATES OF AMERICA

### DATE

10 Date Injury Occurred



Time Injury Occurred

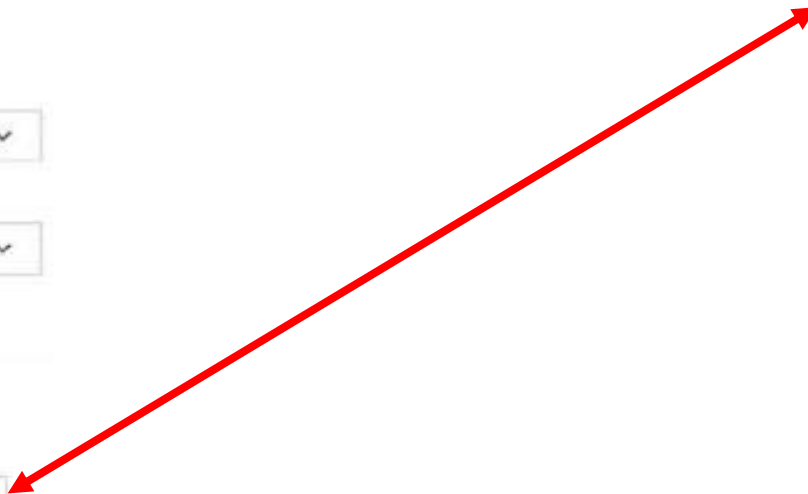


11 Date of this Notice

If you submit this form today, it will be filed on 03/18/2021.

ECOMP wants all data fields filled,  
even if you were injured or fell ill on a base or training  
area, including a street address.

Be specific on the time and date of incident



## DATE


10 Date Injury Occurred Time Injury Occurred

11 Date of this Notice

If you submit this form today, it will be filed on

Employee's Occupation

12 0099 - GENERAL STUDENT TRAINEE 

0099-General Student Trainee

## INJURY

The next two fields have been defaulted from the OSHA-301 form, if present. Please edit if necessary.

Cause of Injury (Describe what happened and why)

13  

(320 characters remaining)

Nature of Injury (Identify both the injury and the part of the body, e.g. fracture of the left leg)

14  

(200 characters remaining)

Autosaved 



EXIT



Be specific - "Sprained left knee after I tripped and fell while running during morning PT"

# CA-1 Traumatic Injury Claim

ECN

Draft



**\* This step is optional.** If you have a statement from a witness who was present at the time of the event, you can upload that statement in the next step. Enter the witness information here. If you do not have a witness statement, you can skip this step by clicking the forward arrow below.

## WITNESS (optional) ?

16

Witness First Name

Middle Name (optional)

Last Name

Address

City

State



Country

ZIP code

UNITED STATES OF AMERICA



Date of Witness Statement

(mm)

(dd)

(yyyy)



Autosaved





## CA-1 Traumatic Injury Claim

ECN | Draft

\* **This step is optional.** You can attach supporting documents to this claim now, or submit them at a later date through ECOMP once a claim number has been assigned. Examples of supporting documents include witness statements, job descriptions, and medical documentation.

**NOTE: Do not upload OWCP forms or medical bills here; they will not be processed.** Medical bills should be submitted using OWCP's Central Bill Processing Center and OWCP forms should be submitted through your agency's established procedures (either electronically or in paper format). Forms or bills submitted as uploads will not be processed.

### ATTACHMENTS (optional) ?

Max file size is 5MB

Limit number of pages to 10 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx



CHOOSE A FILE

Autosaved

**NO MEDICAL BILLS!**

Here you can upload documents relating to your case; witness statements, records of medical treatment, CA-16, etc.

**NO MEDICAL BILLS!**



EXIT



## CA-1 Traumatic Injury Claim

ECN

Draft

**\* This step is optional.** You can attach supporting documents to this claim now, or submit them at a later date through ECOMP once a claim number has been assigned. Examples of supporting documents include witness statements, job descriptions, and medical documentation.

**NOTE: Do not upload OWCP forms or medical bills here; they will not be processed.** Medical bills should be submitted using OWCP's Central Bill Processing Center and OWCP forms should be submitted through your agency's established procedures (either electronically or in paper format). Forms or bills submitted as uploads will not be processed.

### ATTACHMENTS (optional) ?



1 Filename

1 Document Type is required

2

3

1 Authored Date is required.

(mm)

(dd)

(yyyy)



CHANGE FILE

Please ensure documents are oriented correctly to view.

UPLOAD

CANCEL

1

The document is not attached to the case yet. Click the 'Upload' button above to attach it to the case.

Complete these steps for upload, and you will see what is on the following page.

### UPLOADED ATTACHMENTS

## CA-1 Traumatic Injury Claim

ECN  | Draft

\* **This step is optional.** You can attach supporting documents to this claim now, or submit them at a later date through ECOMP once a claim number has been assigned. Examples of supporting documents include witness statements, job descriptions, and medical documentation.

**NOTE: Do not upload OWCP forms or medical bills here; they will not be processed.** Medical bills should be submitted using OWCP's Central Bill Processing Center and OWCP forms should be submitted through your agency's established procedures (either electronically or in paper format). Forms or bills submitted as uploads will not be processed.

### ATTACHMENTS (optional)

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Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tiff, rtf, pdf, doc, docx



CHOOSE A FILE

### UPLOADED ATTACHMENTS

- 
-   DCN  
Type: General Inquiry (Non-Medical) | Authored Date: 03/17/2021  
[View](#)  
Uploaded by march101@ummc.edu on 03/18/2021 at 8:43 AM
  -   DCN  
Type: General Inquiry (Non-Medical) | Authored Date: 03/15/2021  
[View](#)  
Uploaded by march101@ummc.edu on 03/16/2021 at 8:46 AM
  -   DCN  
Type: Medical | Authored Date: 03/13/2021  
[View](#)  
Uploaded by march101@ummc.edu on 03/16/2021 at 8:47 AM

Autosaved 



EXIT





# CA-1 Traumatic Injury Claim

ECN | Draft

Rectangular Ship Edit

## EMPLOYEE BASICS

1

Employee First Name

Middle Name

Last Name

2

Employee Email

Government Organization

RESERVE OFFICER TRAINING CORPS (ROTC)  
RESERVE OFFICER TRAINING CORPS (ROTC)  
ARMY-ROTC CLAIMS  
1240 EAST 9TH STREET, ROOM 851, CLEVELAND, OH, 44199

3

Social Security Number

●●●●●●●●

4

Date of Birth

5

Sex

Female

6

Home Telephone

7

Grade as of Date of Injury

CDT

Step as of Date of Injury

NA

Review your entries for correctness.

## HOME MAILING ADDRESS

[Edit](#)

Address

## DEPENDENTS

[Edit](#)

Dependents

No dependents have been selected

## WHO SHOULD REVIEW THIS FORM?

[Edit](#)

Immediate Supervisor's Email

melissa.l.hoaglin.mil@mail.mil

## DESCRIPTION OF INJURY

[Edit](#)

Place where injury occurred

Arden Hills Army Training Center, Training area 3, 4761 Hamline Avenue, Arden Hills, MN, 55112,  
UNITED STATES OF AMERICA

## DATE

[Edit](#)

Date Injury Occurred

03/13/2021 02:15 PM

Date of this Notice

03/18/2021, if filed today.

Employee's Occupation

[Edit](#)

GENERAL STUDENT TRAINEE

## INJURY

[Edit](#)

### 13 Cause of Injury

Was conducting military movement techniques as part of ROTC training, lost footing on uneven terrain while traversing as a group through movement techniques. Fell and injured left forearm.

### 14 Nature of Injury

Injured left forearm: radial head fracture



## WITNESS

[Edit](#)

### 15 Witness First Name

NO RESPONSE GIVEN

Middle Name

Last Name

NO RESPONSE GIVEN

Address

NO RESPONSE GIVEN

Date of Witness Statement

NO RESPONSE GIVEN

## ATTACHMENTS

[Add/Modify Attachments](#)

DCN

Type: General Inquiry (Non-Medical) | Authored Date: 03/17/2021

Uploaded by march101@um.edu on 03/15/2021 at 8:45 AM

[View](#)

DCN

Type: General Inquiry (Non-Medical) | Authored Date: 03/15/2021

Uploaded by march101@um.edu on 03/13/2021 at 8:46 AM

[View](#)

DCN

Type: Medical | Authored Date: 03/13/2021

Uploaded by march101@um.edu on 03/13/2021 at 8:47 AM

[View](#)

EXIT



# CA-1 Traumatic Injury Claim

ECN | Draft

## SIGN & FILE FORM

Rectangular Snip

17 I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication.

I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ A. Continuation of Regular Pay (COP) ⓘ  
not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ B. Sick and/or Annual Leave

I hereby 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.

Submitting this form is considered the same as signing it.

Do not select A or B. These do not apply to ROTC Cadets.

Select "Sign and File".




EXIT

SIGN AND FILE

## CA-1 Traumatic Injury Claim

ECN  Pending Review by Supervisor

 FORM LOCKED	ECN	CA-1	Pending Review by Supervisor	
	Employee Organization	RESERVE OFFICER TRAINING CORPS (ROTC)	03/13/2021 03/18/2021	Date of Event Initiated
<a href="#">View</a> <a href="#">Upload Attachments</a> <a href="#">Get PDF</a>				

- An email has been sent to your supervisor's email account at
- You will receive email updates each time the status of this form changes.
- Make sure to save/print a copy for your records and note the ECN (ECOMP Control Number).

### Next Steps

- After your claim is reviewed by your supervisor and is received by DFEC, you will receive an email providing a Case Number.
- You can use that case number to file a CA-7, claim for compensation.
- If you want to check on the status of your claim, visit your dashboard.

[DONE](#)

At this point you have completed the first step in the Worker's Compensation process. Your CA-1 is now sent to your supervisor (PMS) for their review and action.

But you are not finished.

You must pay attention to your email and regular mail for communications from the DOL OWCP and respond to them immediately to ensure that all of their requests for action are completed, and that medical bills generated on your behalf get paid.

# SUPERVISOR REVIEW SECTION

[HOME](#)[FORMS](#)[DOCUMENTS](#)[HELP](#)

Rectangular Snip

## Supervisor Review

YOU HAVE BEEN NAMED BY AN EMPLOYEE OF THE US GOVERNMENT TO REVIEW THIS FORM. YOU'RE BEING ASKED TO FILL THIS OUT AS AN EMPLOYEE'S SUPERVISOR SO IT MAY REFERENCE YOU THROUGHOUT AS "THE SUPERVISOR."

ECN   CA-1		Pending Review by Supervisor	
Employee Organization	RESERVE OFFICER TRAINING CORPS (ROTC)	03/13/2021	Date of Event Initiated

YOU SHOULD REVIEW THIS FORM IF BOTH OF THESE ARE TRUE:

Your email is  
You work as a supervisor at the RESERVE OFFICER TRAINING CORPS (ROTC) for the employee named above.

You have received an email from DOL/ECOMP indicating that as a supervisor, you have a case awaiting your review in ECOMP. Clicking the link provided in the email brings you to this page.

If the conditions listed to the left are true, select "Yes, I will review this form".

NO, I CANNOT REVIEW THIS FORM

YES, I WILL REVIEW THIS FORM



Rectangular Snip

## CA-1 Traumatic Injury Claim

ECN  Pending Review by Supervisor

### FORM SUMMARY

Claimant

Email

ECN

Date of Event

Filed

Supervisor

Agency RESERVE OFFICER TRAINING CORPS (ROTC)

Autosaved 

EXIT



## CA-1 Traumatic Injury Claim

ECN

Pending Review by Supervisor

### SUPERVISOR INFORMATION

Agency Official First Name

Middle Name (optional)

Last Name

Agency Official Title

RESERVE OFFICER TRAINING CORPS (ROTC)

Office Telephone

☐

International

### 17 AGENCY NAME AND ADDRESS OF REPORTING OFFICE

Agency Name

RESERVE OFFICER TRAI

Address

15 Church Street SE Rm 110

City

Minneapolis

State

MN - Minnesota



ZIP code

55455

Country

UNITED STATES OF AMERICA



Confirm your information.

Here, Agency Name is "ROTC-  
[your university name]"

## CA-1 Traumatic Injury Claim

ECN Pending Review by Supervisor

## EMPLOYEE BASICS

Employee Occupation Code

0099 - GENERAL STUDENT TRAINEE X

Type Code

FELL, SLIPPED, TRIPPED

Source Code

Physical Training - Tactical, Exercising...

Employee's Retirement Coverage

CERS PERS Other

Identify

N/A

## EMPLOYEE'S SCHEDULE

Does employee work a regular schedule?

Yes No

## DATES

Date of Injury

08/13/2021

Date Notice Received

08/17/2021

Date Employee Stopped Work

[mm] [dd] [yyyy]

Time Employee Stopped Work

Date Employee's Pay Stopped

[mm] [dd] [yyyy]

Date 45 Day Period Begins

[mm] [dd] [yyyy]

Date Employee Returned to Work

[mm] [dd] [yyyy]

Time Employee Returned to Work

Employee Basics; select from drop-downs

0099-General student trainee

[Select appropriate Type Code]

[Select appropriate Source Code]

Select "Other"

Identify is "ROTC Cadet/Student"

Employees Schedule=NO

Confirm Date of Injury and Date Notice Received

24 thru 27=blank

Select "Autosaved" frequently to ensure data is being saved. ECOMP will time out and clear data if no activity is detected.

Submitter: REVIEWER CA-1 SUPERVISOR: REVIEWER: REPORT: PHYSICIAN & WITNESSES: ATTACHMENTS: REVIEW

### CA-1 Traumatic Injury Claim

ECN: Pending Review by Supervisor

#### PHYSICIAN FIRST PROVIDING MEDICAL CARE

First Name: Last Name: Address: City: State: ZIP code: Country: UNITED STATES OF AMERICA

#### MEDICAL

First Date Medical Care Received: Do medical reports show employee is disabled for work? Yes No Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No If employing agency continues continuation of pay, state the reason in detail (otherwise, leave blank): Pay Rate When Employee Stopped Work: Per: I certify that the information I have given and the information furnished by the employee on this form is true to the best of my knowledge with the following exceptions:

Autosound

32. Complete Physician section

33. Complete Medical date

34. If hospitalization or surgery occurred (likely resulting in treatment costs in excess of \$1500), select "Yes". This will not change the eventual disposition of the case; just gets the case in the correct queue initially.

35. Select "Yes" if true

36. [Blank]

37. [Blank]

38. Complete if there are exceptions. Otherwise, blank.



EXIT



## CA-1 Traumatic Injury Claim

ECN | Pending Review by Supervisor



Attach the following supporting documents: witness statements, job descriptions, and medical documentation. Do not upload OWCP forms or medical bills here; they will not be processed. Submit medical bills using [OWCP's Central Bill Processing Center](#). Submit OWCP forms through your agency's established procedures (electronically or in paper form). [Learn more.](#)

### ATTACHMENTS (optional) ⓘ

Max file size is 5MB

Limit number of pages to 10 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tiff, cdf, rtf, pdf, doc, docx



CHOOSE A FILE

Review attachments and add additional ones, if desired.

### UPLOADED ATTACHMENTS

✓ DCN  
Type: General Inquiry (Non-Medical) | Authored Date: 03/17/2021  
[View](#) Uploaded by: march1010@unm.edu on 03/18/2021 at 9:45 AM

✓ DCN  
Type: General Inquiry (Non-Medical) | Authored Date: 03/15/2021  
[View](#) Uploaded by: march1010@unm.edu on 03/16/2021 at 9:46 AM

Autosaved



EXIT



## CA-1 Traumatic Injury Claim

ECN Pending Review by Supervisor

Review this information carefully before continuing.

### SUPERVISOR INFO

[Edit](#)

Agency Official First Name Middle Name Last Name

Agency Official Title  
RESERVE OFFICER TRAINING CORPS (ROTC)

Email & Office Phone

### AGENCY NAME AND ADDRESS OF REPORTING OFFICE

[Edit](#)

Agency Name  
RESERVE OFFICER TRAI

Address  
15 Church Street SE Rm 110, Minneapolis, MN, 55455, UNITED STATES OF AMERICA

### EMPLOYEE BASICS

[Edit](#)

Employee Occupation Code  
0099 - GENERAL STUDENT TRAINEE

Type Code  
FELL, SLIPPED, TRIPPED

Source Code  
Physical Training - Tactical, Exercising, Pack Test, etc

Review data



Other - N/A

## EMPLOYEE'S SCHEDULE

[Edit](#)

Does employee work a regular schedule?

No

## DATES

Rectangular Snip

[Edit](#)

☐ Date of Injury  
03/13/2021

☐ Date Notice Received  
03/17/2021

☐ Date Employee Stopped Work  
NO RESPONSE GIVEN

Time Employee Stopped Work  
NO RESPONSE GIVEN

☐ Date Employee's Pay Stopped  
NO RESPONSE GIVEN

☐ Date 45 Day Period Began  
NO RESPONSE GIVEN

☐ Date Employee Returned to Work  
NO RESPONSE GIVEN

Time Employee Returned to Work  
NO RESPONSE GIVEN

## CAUSE OF INJURY

[Edit](#)

☐ Injured in performance of duty?  
Yes

☐ Misconduct, intoxication, or intent to injure?  
No

☐ Injury caused by third party?  
No

## INJURY DETAILS

[Edit](#)

### INJURY DETAILS

[Edit](#)

Anatomical Location of Injury

AS - SINGLE ARM AND/OR WRIST

Nature of Injury

TF - FRACTURE

Cause of Injury

1G - TACTICAL TRAINING

Extent of Injury



### PHYSICIAN FIRST PROVIDING MEDICAL CARE

[Edit](#)

Physician Name

NO RESPONSE GIVEN

Physician Address

6401 Franch Avenue South, Edina, MN, 55435, UNITED STATES OF AMERICA

### MEDICAL

[Edit](#)

First date medical care received

03/13/2021

Do medical reports show employee is disabled for work?

No

Does supervisor agree?

Yes

Does agency controvert continuation of pay?

NO RESPONSE GIVEN

Pay Rate

NO RESPONSE GIVEN

Remarks

[Edit](#)

## INJURY DETAILS/EXTENT OF INJURY

Most likely the Cadet has incurred a bill for medical services.

Select "X-LT Covered by COP or Leave".

This will cause DOL to create a "Case Number" for the Cadet's claim, which the medical providers will need to reference when submitting their bills for payment.

Do not select any of the other choices in this drop down menu. None of them enable claim follow-up, nor provide a mechanism for medical bill submission and payment.

## MEDICAL

[Edit](#)

First date medical care received  
03/13/2021

Do medical reports show employee is disabled for work?  
No

Does supervisor agree?  
Yes

Rectangular Snip

Does agency controvert continuation of pay?  
NO RESPONSE GIVEN

[Edit](#)

Pay Rate  
NO RESPONSE GIVEN

Remarks  
NO RESPONSE GIVEN

[Edit](#)

## ATTACHMENTS

[Add/Modify Attachments](#)

DCN

Type: General Inquiry (Non-Medical) | Authored Date: 03/17/2021

Uploaded by: murch101@turner.edu on 03/18/2021 at 9:49:49

[View](#)

DCN

Type: General Inquiry (Non-Medical) | Authored Date: 03/15/2021

Uploaded by: murch101@turner.edu on 03/16/2021 at 9:49:49

[View](#)

EXIT





## CA-1 Traumatic Injury Claim

ECN Pending Review by Supervisor

### SIGN

Action to Take

Sign & Forward or File

Request Resubmission

### EVENT (optional)

Is this form related to one of these events? (optional)



EXIT

SIGN AND FORWARD

If CA-1 or CA-2 is correct, select “Sign and Forward or File”.



If there are errors or edits required, select “Request Resubmission”

The optional “Event” will not usually apply to any Cadet claims.

Select “Sign and Forward”

## CA-1 Traumatic Injury Claim

ECN | Pending Final Review by FECA Agency Reviewer

ECN	CA-1	Pending Final Review by FECA Agency Reviewer	
 FORM LOCKED	Employee	03/13/2021	Date of Event
	Organization: RESERVE OFFICER TRAINING	03/18/2021	Initiated
	CORPS (ROTC)		
		<a href="#">View</a>	

- You can print a copy of this form using the 'Get PDF' button above.
- A digital copy of this form will be kept by ECOMP for 5 years. (Public Law 91-596 and 29 CFR 1904)

ISSUE CA-16

DONE

Select “Issue CA-16 (Authorization for Examination And/Or Treatment”, which will allow a download of the form. Provide the form to the Cadet as soon as possible, in order to present to the medical provider(s). Once completed, the form(s) should be returned to the Cadet and uploaded to the case file.

The completed CA-16 is necessary in order to pay the medical providers.

When the download is complete, select “Done”.

# Agency Reviewer Screens



## CA-1 Traumatic Injury Claim

ECN

Pending Final Review by FECA Agency Reviewer

Rectangular Snip

### CLAIM SUMMARY

Claimant

Email

Date of Birth

Social Security Number

Address



ECN

Date of Event 01/06/2022

Filed 01/18/2022

Agency CIVILIAN HUMAN RESOURCES AGENCY

## ATTACHMENTS (optional)

Max file size is 5MB

Limit number of pages to 20 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx



## UPLOADED ATTACHMENTS



[View](#)

DCN

Type: Medical | Authored Date: 01/07/2022

Uploaded by Unknown on 01/18/2022 at 6:14 PM

Angular Snip

EXIT





## CA-1 Traumatic Injury Claim

ECN | Pending Final Review by FECA Agency Reviewer

Review this information carefully before continuing.

### EMPLOYEE BASICS

1 Employee First Name Middle Name Last Name

1a Employee Email

Government Organization

---

2 Social Security Number

●●●●●●●●

3 Date of Birth

4 Sex

Female

Rectangular Snip

5 Home Telephone

6 Grade as of Date of Injury

Step as of Date of Injury

---

## HOME MAILING ADDRESS

7 Address

---

---

8 DEPENDENTS

No dependents have been selected

---

WHO SHOULD REVIEW THIS FORM?

Immediate Supervisor's Email

Rectangular Snip

---

DESCRIPTION OF INJURY

9 Place where injury occurred

---

DATE

10 Date Injury Occurred

01/06/2022 03:00 pm

## DATE

10 Date Injury Occurred  
01/06/2022 03:00 pm

11 Date of this Notice  
01/18/2022

Rectangular Snip

12 Employee's Occupation  
EDUCATION AND TRAINING TECHNICIAN

## INJURY

13 Cause of Injury  
I was standing monitoring an active game for several of the children. A child came running from my left side. He tripped and fell hitting his full weight against the back of my left knee.

14 Nature of Injury  
Bruise of left knee causing pain and inability to stand and walk.

## WITNESS

16

Witness First Name

*NO RESPONSE GIVEN*

Middle Name

Last Name

*NO RESPONSE GIVEN*

Address

*NO RESPONSE GIVEN*

Rectangular Snip

Date of Witness Statement

*NO RESPONSE GIVEN*

---

## ATTACHMENTS

[Add/Modify Attachments](#)



[View](#)

DCN

Type: Medical | Authored Date: 01/07/2022

Uploaded by Unknown on 01/18/2022 at 6:14 PM





## CA-1 Traumatic Injury Claim

ECN

Pending Final Review by FECA Agency Reviewer

Review this information carefully before continuing.

### SUPERVISOR INFO

[Edit](#)

Agency Official First Name

Middle Name

Last Name

Agency Official Title

Assistant Director - Clarkmoor CDC

Email & Office Phone

17 AGENCY NAME AND ADDRESS OF REPORTING OFFICE

[Edit](#)

Agency Name

Address

---

---

EMPLOYEE BASICS

[Edit](#)


a Employee Occupation Code

b Type Code

Struck by

c Source Code

Walking/working surface (floor, street, curbs, porches)

- 
- 19 Employee's Retirement Coverage  
CSRS


[Edit](#)

---

## EMPLOYEE'S SCHEDULE

Rectangular Snip

[Edit](#)

- 
- Does employee work a regular schedule?  
Yes

These are not  
applicable for ROTC

- 20 Regular Work Hours  
01:00 pm - 06:00 pm

- 21 Regular Work Schedule  
Mon, Tue, Wed, Thur, Fri

---

## DATES

[Edit](#)

- 22 Date of Injury  
01/06/2022

## DATES

[Edit](#)

22) Date of Injury  
01/06/2022

23) Date Notice Received  
01/18/2022

24) Date Employee Stopped Work  
01/06/2022

Time Employee Stopped Work  
06:00 pm

25) Date Employee's Pay Stopped  
*NO RESPONSE GIVEN*

26) Date 45 Day Period Began  
01/07/2022

27) Date Employee Returned to Work  
01/11/2022

These do not apply to ROTC claims

## CAUSE OF INJURY

[Edit](#)

) Injured in performance of duty?

Yes

) Misconduct, intoxication, or intent to injure?

No

● Rectangular Snip

) Injury caused by third party?

No



Examples of Third Party Injuries – car accident, injury that resulted from using a defective piece of equipment

---

## INJURY DETAILS

[Edit](#)

Anatomical Location of Injury

KS - SINGLE KNEE

Nature of Injury

TC - CONTUSION

Cause of Injury

99 - CAUSE UNKNOWN

---

## PHYSICIAN FIRST PROVIDING MEDICAL CARE

[Edit](#)

32 Physician Name

Physician Address

---

## MEDICAL

[Edit](#)

33 First date medical care received  
01/07/2022

34 Do medical reports show employee is disabled for work?  
Yes

35 Does supervisor agree?  
Yes

36 Does agency controvert continuation of pay?

[Edit](#)

NO RESPONSE GIVEN

37 Pay Rate

:



Continuation of  
pay does not  
apply to ROTC  
students

38 Remarks

[Edit](#)

NO RESPONSE GIVEN

## ATTACHMENTS

[Add/Modify Attachments](#)



DCN

Type: Medical | Authored Date: 01/07/2022

[View](#)

Uploaded by Unknown on 01/18/2022 at 6:14 PM



# CA-1 Traumatic Injury Claim

ECN

Pending Final Review by FECA Agency Reviewer

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.

Rectangular Snip

## SIGN

Action to Take



Sign & Forward or File	Request Resubmission
------------------------	----------------------

## EVENT (optional)

Is this form related to one of these events? (optional)

▼