U.S. DEPARTMENT OF LABOR Employment Standards Administration

#### REQUEST FOR EXAMINATION AND/OR TREATMENT

Office of Worker's' Compensation Program (OWCP)	LOT TON EXAM	MATION AND/OR TREATMENT					
PART A — AUTHORIZATION							
NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN Sheldon L. Contract, M.D.     123 Oak Street, N.W.     Washington, D. C. 20526	AUTHORIZED TO PR	OVIDE THE MEDICAL SERVICE					
2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo, day, year)	4. OCCUPATION					
DOE, John James	10/29/82	Desk Officer					
DESCRIPTION OF INJURY OR DISEASE     Employee tripped over electrical cord which was in middle of f	loor, fell on right arm	and broke bone in that arm.					
6 YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EI	MPI OVEE SUBJECT T	TO THE FOLLOWING CONDITIONS					
	WII EOTEE GODGEOT	o the roleswing constitions					
A- FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS N OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP A		E EFFECTS OF THIS INJURY. ANY SURGERY,					
B- THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT, YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDER- SIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT,							
<ol> <li>IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR I OBTAINED FROM</li> </ol>	SSUING AUTHORIZAT	TION UNDER ITEM 6B ABOVE, WAS					
(Name of OWCP official)							
8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies-)	9. TITLE						
David Alexander	Chief of Operations						
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	11. DATE (mo., day,	year)					
423-1234	10/29/82						
12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)	13. NAME AND ADDRESS OF EMPLOYEES PLACE OF EMPLOYMENT,						
U. S. DEPARTMENT OF LABOR Employment Standards Administration	Dept or Agency Peace Corps						
Office of Workers' Compensation Programs	Bureau of Agency- Africa Operations						
	Local Address 806 Connecticut Avenue, N.W. (including; Zip Code) Washington, D. C. 20526						

#### INSTRUCTIONS TO AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

### SELECTION OF PHYSICIAN

A Federal employee injured by accident while in the performance of duty
has the right to select a physician of his/her choice to provide necessary
treatment. The supervisor shall immediately authorize examinat; on and
appropriate medical care by use of Form CA-16 issued to either a
United States medical officer/hospital or any duly qualified physician/
hospital of the employee's choice

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be cons;dered.

### FEDERAL MEDICAL FACILITIES

 U. S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities health units) established under 5 USC 7901 are not U. S. medical facilities as used herein.

### DEFINITION OF INJURY

 The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which requires medical services.

### DEFINITION OF PHYSICIAN

 The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practioners within the scope of their practice as defined by State law.

#### PRIOR ARRANGEMENTS

 The physician or medical facility to which employee is being referred, shall be contxted by the supervisor to confirm availability before authorization is issued

#### ILLNESS OR DISEASE

 Treatment for illness or disease shall not be authorized unless approval is first obtained from the OWCP.

## FORM COMPLETION

 Part A shall be completed in full by the authorizing official. Check Box A or B of item 6, whichever is appropriate. In case of illness or disease only Box B may be checked.

Show the address of proper OWCP Office in item 12. Send original and one copy of the CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to the OWCP.

# ADDITONAL INFORMATION

• See 20 CFR 1 and/or Chapter 810, Federal Personnel Manual (FPM).

Information For Physician - See Reverse Side

PART B—ATTENDING PHYSICIAN'S REPORT								
14. EMPLOYEE'S NAME (last, first, middle)								
15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?								
16. IS THERE AN' (If yes, please		OF PRE-EXISTING INJURY	Y, DISEASE, OR	PHYSICAL IMP	AIRMEN <sup>*</sup>	T?		
☐ <sub>Ye</sub>	es $\square$ No							
17. WHAT ARE YO test, etc.)?	17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory test, etc.)?  18. WHAT IS YOUR DIAGNOSIS?							
19 . DO YOU BEL (If explain your	IEVE THE CONDITION FO answer if there is doubt.)	UND WAS CAUSED OR AG	GRAVATED BY	THE EMPLOYM	IENT AC	TIVITY DESC	RIED?	
☐ <sub>Ye</sub>	es $\square$ No							
20. DID INJURY REQUIRE HOSPITALIZATION?  (If yes, date of admission (mo., day, year))				21. IS ADDITIONAL HOSPITALIZATION REQUI RED				
Date of discharge (mo., day, year)			Yes No					
22. SURGERY (If any, describe type)			23. DATE SURGERY PERFORMED (mo., day, year)					
24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?				25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?				
26. DATE OF FIRS (mo., day, year	ST EXAMINA-TIONAL r)	27. DATE(S) OF TREATMENT (mo., day, year)			28, DATE OF DISCHARGE FROM TREAT- MENT (mo., day, year)			
29. PERIOD OF D INDICATED)	NSABILITY (IF TERMINATI (mo., day, year)	ON DATE UNKNOWN, SO	30. DATE EMPL	OYEE ABLE TO	O RESUN	//E WORK (m	o., day, year)	١
TOTAL DISAB PARTIAL DISA	ILITY: FROM ABILITY: FROM	TO TO	T WORK ULAR WORK	RK				
31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? Yes No IF YES, FURNISH DATE ADVISED (month, day, year)								
32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY 8E PERFORMED WITH THESE LIMITATIONS								
33. GENERAL RE	MARKS AND RECOMMEN	NDATION FOR FUTURE CA	RE IF INDICATE	D				
34. DO YOU SPEC	CIALIZE? Yes	No (If yes, state spead	cialty)					
35. SIGNATURE OF PHYSICIAN  36. ADDRESS (Number, street, city, state, zip code)  37. PHYSICIAN 5 SOCIAL SERCURITY NUMBER				,				
			2			`		
			38. DATE OF REPORT (mo., day, year)					
39. MEDICAL. Charge for you services may be presented in the space below or your billhead stationary.								
Dates of			Quality	Unit price		Amount		
period of reatmentt	Service	or supplies must be itemized		of number	Cost	Per	\$	\$

	TOTAL			

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#### INFORMATION FOR PHYSICIAN

### YOUR AUTHORIZATION

 Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in item 5, subject to the conditions in item 6.

### USE OF CONSULTANTS AND HOSPITALS

 You may use consultants, laboratories and local hospitals, if needed. Use simi-private accommodations unless a private room is medically necessary.
 If hospitalized, necessary ancillary treatment may be provided.

#### **REPORTS**

• After examination, complete items 14 through 38 Part B) and promptly send your report to the address listed in item 12 of Part A. If additional space is needed or a narrative report is made, attach it to the form. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA-17 "Duty Status Report" will be required during the first 45 days of disability. The "Duty Status Report" will be requested by the employing agency. If disability continues beyond 45 days, monthly reports on OWCP forms or by physician's narrative should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of compensation.

### RELEASE OF RECORDS

 Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

#### **FEES**

OWCP does not have a specific fee schedule. Local usual and customary
rates are acceptable. Payment for chiropractic services is limited to
charges for physical examinations, related laboratory tests, X-rays to
diagnose a subluxation of the spine and treatment consisting of
manipulation of the spine to correct a subluxation demonstrated by X-ray.
Submit itemized bill by completing item 39 of Part B, or on your billhead stationery. Bills for any further treatment may be submitted with
your progress reports.

# ADDITIONAL INFORMATION

· Contact OWCP office shown in item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

Washington, D.C. 20402 (per 10 copies) Stock No. 029-016-00025-9 Catalog Number L 7. FORM CA16