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Attending Physician's Report

U.S. Department of Labor

Office of Workers' Compensation Programs

Record of Examinaton

1. Patient's name * Last First Middle | 2. Date of Injury * mo, day yr | 3. OWCP File Number * | OMB No. 1240-0046 Expires: 09-30-2011

4. What history of injury (including disease) did patient give you? *

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? * (If yes, please describe) ☐ Yes ☐ No | ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.) *

7. What is your diagnosis? * | ICD-9 Code *

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) * ☐ Yes ☐ No

9. Did injury require hospitalization? * If no, go to item # 13 ☐ Yes ☐ No | 10. Date of admission mo, day yr. | 11. Date of discharge mo, day yr. | 12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination * mo, day yr. | 15. Date(s) of treatment: mo, day yr. mo, day yr. mo, day yr. | 16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo, day yr. | 18. Period of Partial Disability From mo. day yr. Thru mo. day yr. | 19. Date employee able to resume light work mo, day yr.

20. Date employee is able to resume regular work mo, day yr. | 21. Has employee been advised that he/she can return to work? * ☐ Yes ☐ No | 22. If yes, on what date was he/she advised? mo, day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.) | 24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. * ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name | Specialty
Address
City State ZIP
27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. 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 felony criminal prosecution. *
Signature of Physician Signature * Date

29. Name of Physician * | 30. Tax ID Number *
Address * | 31. Do you specialize? * ☐ Yes ☐ No
City * State ZIP | 32. If yes, indicate specialty

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS 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 USC 8101 et seq.).

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DOL DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, 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 these estimates or any other aspect of 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, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

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Washington, DC 20402

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

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 verity 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 filed under the FECA.