Claim for Schedule Award

Reset Print

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

SECTION 1: CLAIMANT CONTACT INFORMATION

a. Name of Claimant *Last*	*First*	*Middle*	OMB No. 1240-0064 Expires: 10/31/2027
b. Mailing Address (*Street, City, State, ZIP Code*)			c. OWCP File Number
	d. Date of Injury		e. Social Security Number
f. Email Address	g. Phone Number		

SECTION 2: COMPENSATION CLAIMED

Compensation is claimed for:

a. ☐ Schedule Award/Impairment.

For which covered member(s) (i.e. left arm, right leg, etc.) do you claim impairment as the result of your accepted, work-related injury?

Please review instructions for further information regarding qualifying scheduled members.

b. ☐ Disfigurement (head/face/neck). Photographs are required. *Please review instructions for further information regarding a claim for disfigurement.*

c. Is this the first claim for Schedule Award/Impairment that you have filed under this or any previous claim under the Federal Employees' Compensation Act (FECA)?

☐ YES ☐ NO

If only claiming disfigurement, proceed to section 4. Otherwise, proceed to section 3.

SECTION 3: IMPAIRMENT RATING EXAMINATION

☐ **Check here if your physician performed an impairment rating examination pursuant to the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), Fifth or Sixth Edition (see instructions), and you are submitting the rating report along with this claim. If you select this option but no impairment rating or a deficient rating is submitted with your claim, the OWCP may arrange for you to be examined by an appropriate specialist.**

☐ **Check here if you are not submitting an impairment rating report along with your claim. The OWCP may arrange for you to be examined by an appropriate specialist (see instructions).**

☐ **Deferred Adjudication (see instructions). Your claim form will be placed in the case file but no further action will be taken at this time.**

SECTION 4: DEPENDENTS

a. **List your dependents (including spouse).** You may provide additional dependent information on a separate page. If your child is 18 or over, you **must** either submit evidence from the school registrar of full-time student status, or provide a medical report from a physician establishing your child is physically or mentally incapable of self-support.

Name	Social Security #	Date of Birth	Relationship	**Living with you? If no, complete b.**
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

b. Are you making regular support payments for a dependent shown above? ☐ YES ☐ NO If yes, support payments are made to:

Name	**Address**	**City**	**State**	**ZIP Code**

Were support payments ordered by a court? ☐ YES ☐ NO **If Yes, attach copy of court order.**

If you have a disability and need communication assistance (alternate formats or sign language interpretation), accommodations, and/or modifications, please contact OWCP. See instructions for Requests for Accommodations or Auxiliary Aids and Services.

SECTION 5: DEPARTMENT OF VETERANS AFFAIRS' BENEFITS

a. Have you ever applied for or received disability benefits from the Department of Veterans' Affairs (DVA)?

☐ YES ☐ NO If yes, provide:

Claim Number: _____ Date Benefit Began: _____ Monthly Payment:$ _____

Type of Disability (body part) & Percentage: _____

b. Has the percentage of award increased since your date of injury? ☐ YES ☐ NO *If yes, provide a copy of the rating notice.*

c. DVA Address: _____ City: _____ State: _____ ZIP Code: _____

DVA Phone Number:

Please note: Failure to update a change in your DVA benefits may result in an improper payment.

SECTION 6: CLAIMANT CERTIFICATION OF CLAIM

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

Claimant's Signature _____ Date (*Mo., day, year*) _____

SECTION 7: REMARKS

Provide any remarks or comments:

SECTION 8: AGENCY CERTIFICATION

An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact with respect to this claim (or impedes the filing of a claim) may also be subject to appropriate criminal prosecution. I certify that the information furnished by the employee on this form is true to the best of my knowledge.

Agency Official's Signature _____ Date _____

Title _____ Phone # _____ E-mail Address _____

Name of Agency _____

Date Claim Form Received From Employee _____

Name/phone number of person OWCP may contact for pay information

INSTRUCTIONS FOR COMPLETING COMPENSATION CLAIM FOR SCHEDULE AWARD

If additional space is needed to respond to questions on this form, attach a separate sheet of paper. Write the claimant's full name and case number on the separate sheet(s). Write, "see attachment" in the applicable portion of the form.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R. § 10.103 and 20 C.F.R. § 10.404.

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

CLAIMANT (or person acting on the Claimant's behalf) - Complete sections 1 - 6 as directed and submit the form to the Claimant's supervisor. Note: If you receive SSA disability benefits, those SSA disability benefits may be reduced by SSA due to your receipt of FECA benefits.

SUPERVISOR (or appropriate official in the employing agency) - Complete sections 7 - 8 as directed and promptly forward the form to the OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2. (a) Schedule Impairment	Schedule impairment awards are paid for permanent impairment to a member or function of the body pursuant to Federal Employees' Compensation Act (FECA) Section 8107. Covered members are listed in 20 C.F.R. § 10.404 and include: Arm, Leg, Hearing Loss, Hand, Foot, Thumb, 1st Finger, 2nd Finger, 3rd Finger, 4th Finger, Skin, Eye, Lung, Kidney, Tongue, Larynx, Penis, Testicle, Vulva/Vagina, Uterus/Cervix, Breast, and Ovary/fallopian tubes.
2. (b) Disfigurement	Disfigurement must be of the face, head, or neck that handicaps an individual in securing or maintaining employment. This type of schedule impairment will not be considered until at least six (and preferably 12) months after the last medical treatment. You should include with this form two photographs taken within five days of the date your disfigurement claim is filed. Each photograph must show different views of the disfigurement, fairly and accurately portrayed. An award for disfigurement may be paid concurrently (at the same time) with a schedule impairment award.
3. Impairment Rating Examination	**If you are submitting a medical report containing an impairment rating from your attending physician it should include:** 1. The date your condition reached maximum medical improvement. Maximum medical improvement refers to a date from which further recovery or improvement is not anticipated, and the clinical findings demonstrate that the medical condition(s) is static and well-stabilized. 2. The diagnosis on which the impairment is based, including any related surgery, and a detailed description of all pertinent objective findings and subjective complaints. 3. A detailed description of any permanent impairment of the same member or function which pre-existed the injury. 4. A final rating of the permanent impairment and a discussion of the rationale for calculation of the impairment, with references to the applicable criteria and tables in either the Fifth Edition (2000 printing) or Sixth Edition (Second Printing, April 2009) of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, based on which guides your physician deems most medically appropriate to rate the condition(s) being evaluated. This rating should be expressed in terms of percentage of loss of use of the affected member(s) or function of the body (not the body as a whole except when the Guides only provide such a rating, such as for the lung, skin or other organs). For impairment ratings being made under the Sixth Edition, if the Guides allow for the use of both the Diagnosis-Based Impairment (DBI) and Range of Motion (ROM) methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used. In these situations, your physician should independently calculate the impairment using both the ROM (three (3) independent measurements should be documented/ recorded and the greatest ROM should be used) and DBI methods and identify the higher rating. If your physician uses the QuickDASH form to report functional ability, this should be discussed in his/her report.

Also, please note as the Guides caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three (3) independent measurements should be documented/recorded and the greatest ROM should be used for the determination of impairment.

Special Instructions for Spinal Impairment: Under the provisions of the FECA, awards for permanent impairment may not be paid for the spine. However, such awards can be paid for impairment of the upper or lower extremities caused by injury to a spinal nerve. Therefore, if there is a work-related spinal nerve injury which has caused impairment to the extremities, the impairment rating of the affected extremities must be computed by using the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment, given the Sixth Edition does not allow for such a rating.

Special Instructions for Skin Impairment: The report submitted should also include information with respect to (1) the variability in the skin condition over time (2) documentation of the Burden of Treatment required to control the skin condition when removal from exposure has not resulted in resolution of the skin condition and (3) the impact on the worker's life activities.

If you are claiming a schedule award for hearing loss, the OWCP will arrange for you to be examined by an appropriate specialist. A hearing loss claim requires both an audiological evaluation and an otologic examination complete with proper certifications. Any medical evidence submitted with this claim will be provided to the reviewing physician for consideration.

If you select to have OWCP arrange for you to be examined by an appropriate specialist or if you fail to submit an appropriate medical report from your attending physician, OWCP will schedule you for an examination in your area as long as your case file reflects some evidence of impairment to a scheduled member. If there is no evidence of any impairment to a scheduled member in your case file, your schedule award claim may be denied.

Deferred adjudication may be selected in situations where you wish to claim a Schedule Award that is not payable at this time. By filing a Form CA-9, you are preserving your statutory right to file your claim for Schedule Award/Impairment during your lifetime. Under 5 U.S.C. 8109, a valid claim for a schedule award, in writing, filed by the employee or someone on his behalf must be made during the employee's lifetime.

An example where deferred adjudication may be appropriate:

If maximum medical improvement (MMI) has not been obtained. MMI is defined as a stable and fixed state for the medical condition; no further recovery or improvement is expected even with additional medical treatment. A condition is at MMI if it is not expected that the condition will change or progress. By filing a Form CA-9, you are preserving your statutory right to file your claim for Schedule Award/Impairment during your lifetime. Under 5 U.S.C. § 8109, a valid claim, in writing, filed by the employee or someone on his behalf must be made during the employee's lifetime.

4. Dependents	Your spouse is a dependent if he or she is living with you, or does not live with you, but you provide financial support to your spouse, including health insurance coverage through your Federal Employees' Health Benefits Program. A child is a dependent if he or she either lives with you or receives regular support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability.
5. Dual Benefits - DVA	An election is required when the disability of a claimant has resulted from an injury sustained in civilian employment by the United States, and the Department of Veterans Affairs (DVA) has held that the same disability, or increase in disability, was caused by their military service.
6. Claimant Certification of Claim	Your acknowledgement, signature, and date is required in order to proceed with your Schedule Award/ Impairment claim.

Employing Agency Verification (to be completed by your Employing Agency)

7. Remarks	Provide any additional relevant information.
8. Agency Certification	Provide agency official's signature, date, and contact information.

The authority for requesting this information is 5 U.S.C. § 8101 *et seq.* The information will be used to determine entitlement to benefits.

Furnishing the requested information is required for the Claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. § 552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary (5 U.S.C. § 8101 *et seq.*) to obtain or retain a benefit. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210, and reference the OMB Control Number 1240-0046. **Note: Do not submit the completed claim form to this address.**

Privacy Act Statement

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 healthcare 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, to verify earnings without further written authorization, 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.