



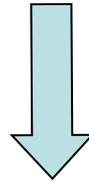
Filing Claims using Electronic Data Interchange

DoD Civilian Personnel Management Service
Injury and Unemployment Compensation Division

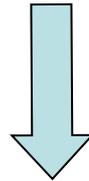
- It has been DoD policy since July 2003 to utilize EDI when submitting claims
- DOL will be monitoring agency timeliness for claim submission as a result of SHARE
- Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim submission

- Claims filed utilizing EDI are electronically transmitted to OWCP from the agency
- Any delay due to internal routing of paper claims and mailing forms to OWCP are eliminated

Greater use of EDI



Greater number of timely filed claims



Better outcomes for injured workers
& meeting DoD and SHARE goals

Safety First Electronic Reporting (SAFER)

- DOL has made a determination as to which claim data can be shared with an organization's safety office in order to assist in fulfilling OSHA reporting requirements
- EDI/SAFER provides the data to safety in the form of an OSHA 301 notice. This 301 notice provides safety with the data they need to start their reporting and investigations

Safety First Electronic Reporting (SAFER)

- EDI/SAFER is not a replacement for any existing safety applications or requirements
- Unsanitized copies of CA-1s or CA-2s are no longer to be given to the safety office

- *To be given access to EDI you must:*
 - Serve as the Injury Compensation Program Administrator (ICPA) for your agency
 - Submit an access request for DIUCS / EDI through your Liaison
 - Have a DIUCS User ID and password established

- Employee reports the injury to his/her supervisor
- Process is started by accessing the EDI website
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access

- ICPA receives an email notification of the supervisor's claim submission
- ICPA will receive, via email, a copy of the OSHA 301 to forward to the appropriate Safety Office if that Safety Office does not have an established alias

- ICPA accesses the EDI application using their User ID and password
- ICPA “authenticates” the form (i.e. verifies employment status, enters appropriate codes, corrects any errors); form is then transmitted to DOL

- If there are no problems with the claim, the ICPA will receive an email with the case number within 2-3 business days
- If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection

ICUC Division

Injury and Unemployment Compensation Division

- ▶ About Injury Compensation
- ▶ About Unemployment Compensation
- ▶ **Filing Claims Electronically** (supervisor's link)
- ▶ DIUCS v.2.1 (password required)
- ▶ DIUCS SSO (password required)
- ▶ DEFPAC (password required)
- ▶ FTP
- ▶ Iraq Provincial Reconstruction Teams
- ▶ NSPS
- ▶ MYBIZ

CPMS Home

Items of Interest

How Do I File an



The EDI application for Supervisors can be accessed through the ICUC Web page.

The URL for the Web page is http://www.cpms.osd.mil/ICUC/ICUC_index.aspx

Select the link to the left titled "Filing Claims Electronically"

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In
DIUCS users
DIUCS service will be interrupted on the morning of Wednesday, May 30th, to introduce improvements. The transition to a new identity management function will require users to change their passwords. If you do not access the system and change your password during the transition period, you will need to reapply for access. For details...
»More

DoD Pipeline Program - Creating Opportunities for Recovering Employees
»More

- Modify ICUC System Access
- *Additional Resources*

Human Resources Policies

- Civilian Personnel Manual (CPM) Subchapter 810 Injury Compensation
- Civilian Personnel Manual (CPM)

The EDI forms are patterned directly on the hard copy forms CA-1 and CA-2. Therefore, the basic instructions for completing the forms are the same as with paper

This DoD computer system including all related network devices (specifically including internet access) is for U.S. Government use. DoD computer systems may be monitored, including to ensure authorized use, for system management against unauthorized access, and to verify security and operational security. Monitoring includes active attacks by authorized DoD entities to test or verify the security of this system. During monitoring, information may be examined, recorded, copied and used for authorized purposes. All information, including personal information, placed on or sent over this system may be monitored. Use of this DoD computer system, authorized or unauthorized, constitutes consent to monitoring. Unauthorized use may subject you to criminal prosecution. Evidence of unauthorized use collected during monitoring may be used for administrative, criminal or other adverse action.

After selecting the link on the ICUC Web page, this screen will open. The user will need to read and select OK in order to continue.

OK

Cancel

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

When the initial claim entry screen appears, the employee's SSN and DOB will be entered and type of claim form will be selected.

Claim Form Type

- CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Compensation
- CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Exit

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

Claim Form Type

- CA-1 Federal Employee's Notice of Traumatic Injury and Compensation
- CA-2 Notice of Occupational Disease and Claim for Compensation

Once the employee's information is added, select the Enter claim button to begin entering data.

Enter claim

saf 01.

1. Name of employee
 Last Name: First Name:
 Middle Name: Suffix:
 2. Social Security Number

3. Date of birth MM-DD-YYYY

4. Sex
 Male Female

5. Home Phone

6. Grade as of date of injury
 Level: Step:

7. Employee's home mailing address
 Street Address:
 City:
 State: ZIP Code:

8. Dependents
 Wife, Husband
 Children under 18 years
 Other

Claim information
 EDI claim number: Status:
 Trading partner ID: Status time:

The form will now open with the employee's information populated into the appropriate fields using data from the personnel system.

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee		2. Social Security Number	
Last Name: SMITH	First Name: JOHN	111-11-1111	
Middle Name: <input type="text"/>	Suffix: (not entered)		
3. Date of birth MM-DD-YYYY 01-01-1960	4. Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	5. Home Phone <input type="text"/>	6. Grade as of date of injury Level: WG10 Step: 05
7. Employee's home mailing address Street Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> ZIP Code: <input type="text"/>		8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years	

White fields are required to be filled in.

Yellow fields are optional and do not have to be filled in.

Gray fields are informational and cannot have data entered into them.

1. Name of employee
 Last Name: First Name:
 Middle Name: Suffix:
 2. Social Security Number

3. Date of birth MM-DD-YYYY

4. Sex
 Male Female

5. Home Phone

6. Grade as of date of injury
 Level: Step:

7. Employee's home mailing address
 Street Address:
 City:
 State: ZIP Code:

8. Dependents
 Wife, Husband
 Children under 18 years
 Other

Some fields require the data entered to be in a particular format. For example, phone numbers should be entered without using any () or -

Claim information
 EDI claim number: Status:
 Trading partner ID: Status time:

1. Name of employee
Last Name: First Name:
Middle Name: Suffix:

2. Social Security Number

3. Date of birth MM-DD-YYYY

4. Sex
 Male Female

5. Home Phone

6. Grade as of date of injury
Level: Step:

7. Employee's home mailing address
Street Address:
City:
State: ZIP Code:

Claim information
EDI claim number: Status:
Trading partner ID: Status time:

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

RM-40209: Field must be of form FM9999999999999999

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee
Last Name: SMITH First Name: JOHN
Middle Name: [Yellow Box] Suffix: (not entered)
2. Social Security Number: 111-11-1111

3. Date of birth MM-DD-YYYY: 01-01-1960
4. Sex: Male Female
5. Home Phone: 123456789
6. Grade as of date of injury
Level: WG10 Step: 05

7. Employee's home mailing address
Street Address: 123 MAIN STREET
City: ANYTOWN
State: FL ZIP Code: [Empty Box]

8. Dependents

Claim information
EDI claim number: [Empty Box] Status: [Empty Box]
Trading partner ID: FECAEDI Status time: [Empty Box]

Display List of Corresponding Zip Codes - Press CTRL + L

Record: 1/1

Warning: Applet Window

A message will also be displayed at the bottom of the screen when a dropdown box is available for a field. Fields with Zip Codes have this function. To activate the box, place the cursor in the field and hold down the CTRL and L keys at the same time.

Display List of Corresponding Zip Codes - Press CTRL + L

A box will appear that allows the available entries in that field to be searched

1. Name of employee

Last Name: First Name:

Middle Name: Suffix:

3. Date of birth MM-DD-YYYY:

4. Sex: Male Female

5. Home Phone:

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

Claim information

EDI claim number:

Trading partner ID:

Listing of Zip Codes

Find:

STATE	CITY	ZIP CODE
FL	FLEMING ISLAND	32006
FL	ORANGE PARK	32006
FL	BOSTWICK	32007
FL	BRANFORD	32008
FL	BRYCEVILLE	32009
FL	CALLAHAN	32011
FL	DAY	32013
FL	LAKE CITY	32024
FL	LAKE CITY	32025
FL	FLORIDA DEPT OF CORR	32026

Find OK Cancel

1. Name of employee
 Last Name: SMITH First Name: JOHN
 Middle Name: Suffix: (not entered)
 2. Social Security Number
 111-11-1111

3. Date of birth MM-DD-YYYY
 01-01-1960
 4. Sex
 Male Female
 5. Home P

7. Employee's home mailing address
 Street Address: 123 MAIN STREET
 City: ANYTOWN
 State: FL ZIP Code:

Claim information
 EDI claim number:
 Trading partner ID: FECAEDI

Listing of Zip Codes

Find FL%

STATE	CITY	ZIP CODE
FL	FLEMING	
FL	ORANGE	
FL	BOSTON	
FL	BRANFORD	
FL	BRYCEVILLE	
FL	CALLAHAN	
FL	DAY	
FL	LAKE CITY	
FL	LAKE CITY	32025
FL	FLORIDA DEPT OF CORR	32026

Find OK Cancel

Entering a state before the % (i.e. FL%) will display all the Zip Codes for that state

Entering a State before the % and city after (i.e. FL%Miami) will display all the Zip Codes for that city.

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL

FLEMING ISLAND FL

10. Date & time injury occurred

MM-DD-YYYY HH:MM [AM|PM]

01-20-2005 02:30 PM

11. Date of this notice

MM-DD-YYYY

01-20-2005

13. Cause of injury (Describe what happened and why)

I WAS WALKING DOWN THE STAIRS AND I TRIPP

14. Nature of injury (Identify both the injury and the part of body, e

BROKEN NOSE, BRUISED RIBS

The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

Nature of Injury

Anatomical location code

Part of Body Side of Body

15. 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 beyond 45 days. If my claim is denied, I understand that I may be required to use my sick leave, annual leave, or be deemed an overpayment within the 45-day period.
- b. Sick and/or Annual Leave
- c. Unknown

The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application.

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.

Signature of employee or person acting on his/her behalf _____ Date

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 felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Enter a witness statement in this space. The witness will sign the statement when the claim form is printed.

If there is no statement, leave this space blank.

If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information. Send the separate signed witness statement to the ICPA.

Name of Witness: Last Name First Name Middle Name

_____ . _____ _____

Signature of witness: _____ Date signed: _____ MM-DD-YYYY

Street Address: _____

City: _____

State: _____ ZIP Code: _____

Enter the required information in the appropriate fields. Paying attention to the format for data entry. (No military time)

17. Agency name and address of reporting office

Agency name: GOVERNMENT AGENCY

Street Address: 123 WORK STREET

City: ANYTOWN

State: FL ZIP Code: 32006

OWCP Agency Code

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

CSRS FERS OTHER (identify)

20. Regular work hours

HH:MM [AM|PM] HH:MM [AM|PM]

From: 09:00 AM To: 05:30 PM

21. Regular work schedule

Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]

[Redacted]

25. Date pay stopped
MM-DD-YYYY

26. Date 45 day period began
MM-DD-YYYY

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]

28. Was employee injured in performance of duty?

Yes No (If "No", explain)

If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided . Otherwise leave the box checked "yes."

If the information will not fit into this box, annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?

Yes (If "Yes", explain) No

If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"

If the information will not fit into this box annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

30. Was injury caused by third party?

Yes

No

31. Name and address of third party (include city, state, and ZIP code)

3rd party name: [Redacted]

name continued: [Redacted]

Street Address: [Redacted]

City: [Redacted]

State: [Redacted] ZIP Code: [Redacted]

Example of a third party claims would be an automobile accident in which the other driver was found to be at fault.

32. Name and address of physician first providing medical care (Include city, state, and ZIP code)

Last Name	First Name	Middle Name	Title
[Redacted]	[Redacted]	[Redacted]	[Redacted]

Street Address: [Redacted]

City: [Redacted]

State: [Redacted] ZIP Code: [Redacted]

If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)

33. First date medical care received

MM-DD-YYYY

[Redacted]

33a. Provided by Agency medical facility?

Yes No

34. [Redacted]

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

If, in the investigation of the claim, nothing contradicting the employee or witness is uncovered, it would be appropriate to answer "yes". The supervisor does not have to witness the alleged incident to answer "yes".

If an investigation has been started, but the results are not available at the time of claim filing, then annotate "investigation in progress, results forwarded under separate cover". The ICPA should be provided with a copy of the results to forward to OWCP

36. If the employing agency controverts continuation of pay, state the reason in detail.

[Empty text area for question 36]

37. Pay rate when employee stopped work

Amount: Per:

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space. If the information will not fit, then annotate "additional information will be forwarded under separate cover" and forward the information to the ICPA

36. If the employing agency controverts continuation of pay, state the reason in detail.

[Empty text area for question 36]

37. Pay rate when employee stopped work

Amount: [Empty text box] Per: <not entered>

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

Yes No (If "No", explain)

[Large yellow text input area for question 35]

36. If the employing agency controverts continuation of pay, state the reason in detail.

Enter the reason for the controversion of COP in this space.

37. Pay rate when employee stopped work

Amount: Per:

Work Environment Exceptions

- Employee was member of general public rather than
- Injury resulted from non-work related event or exp
- Injury resulted from voluntary participation in a we
- Injury resulted from employee eating, drinking, or
- Injury resulted from personal grooming, self medi
- Injury resulted from a motor vehicle accident occu
- Injury is the common cold or flu.

Privacy Case Status:

A

Not A Privat

Check all that apply for the sections on this tab. This information will be used to generate the OSHA 301 notice used for safety notification (Unique to EDI/SAFER) and will not be sent to OWCP.

General Recording Criteria

- Employee is deceased as a result of the incident.
- Employee suffered days away from work as a result of the incident.
- Employee's work activity was restricted as a result of the incident.
- Employee was treated in an emergency room as a result of the incident.
- Employee was hospitalized overnight as an in-patient.
- Employee lost consciousness as a result of the incident.
- Employee was transferred to another job as a result of the incident.

Injury Classification:

A

Injury

Preliminary OSHA Recordability

29 CFR 1960:

RECORDABLE

OSHA 200 Log Coding:

6

29 CFR 1904:

RECORDABLE

OSHA 300 Log Coding:

J,1

As Of:

01-20-2005 02:53:38 PM

Work Environment Exceptions

- Employee was
- Injury resulted
- Injury is the common

Using CTRL+L when the cursor is placed in the Privacy Case Status field will display the listing of values for that field.

Privacy Case Status:

A

Not A Privacy Case

General Recording

- Employee is dec
- Employee suffer
- Employee's wor
- Employee was t
- Employee was h
- Employee lost c
- Employee was t

Injury Classification

View Claim

Choose a Valid Privacy Case Code

Find %

Privacy Case Description	Code
D	HIV Infection
E	Hepatitis
C	Mental Illness
G	Needlestick
A	Not A Privacy Case
H	Personal Request
B	Sexual Assault
F	Tuberculosis

Find OK Cancel

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, or omission may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

If an on-site investigation was performed then a root cause will have to be entered.

Was an on-site investigation conducted?
 Yes No

What was the root cause of this injury?
[Redacted]

Name of Supervisor: Last Name: SUPERVISOR, First Name: JOE, Middle Name: [Redacted]

Signature of supervisor: _____ Date signed: 01-20-2005

Supervisor's Title: SUPERVISOR, Supervisor's Email Address: jsupv@govt.mil, Supervisor's Office phone number: 1234567890

39. Filing Instructions
 No lost time and no medical expense: Place this form in employee's medical file
 No lost time, medical expenses incurred or expected: forward this form to OWCP
 Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 First Aid Injury

The supervisor's email address should be entered in this field.

View Claim | Submit Claim | Cancel | Exit

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

[Yellow input field]

Name of Supervisor: Last Name: SUPERVISOR, First Name: JOE, Middle Name: [Yellow input field]

Signature of supervisor: _____ Date signed: 01-20-2005

Supervisor's Title: SUP Supervisor's Email Address: jsupv@govt.mil Supervisor's Office phone number: 1234567890

Verify the email address

39. No lost time, medical expenses incurred or expected: forward this form to... Lost time covered by leave, LWOP, or COP: forward this form to... First Aid Injury

Email Validation dialog box: Please re-type your email address here, before you can continue, then press OK. jsupv@govt.mil [OK]

View Claim Submit Claim Cancel Exit

Window

- Emp. Data
- Injury
- Emp. Signature
- Witness
- Sup Rpt 1
- Sup Rpt 2
- Sup Rpt 3
- Sup Rpt 4
- Safety Data
- Sup Signature

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of

[Redacted]

Select the appropriate filing instructions.

Last Name

Middle Name

Name of Supervisor:

SUPERVISOR

[Redacted]

MM-DD-YYYY

Signature of supervisor:

Date signed:

01-20-2005

Supervisor's Title

SUPERVISOR

Supervisor's Email Address:

jsupv@govt.mil

Supervisor's Office phone number

1234567890

39. Filing Instructions

- No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- No lost time, medical expenses incurred or expected: forward this form to OWCP
- Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- First Aid Injury

View Claim

Submit Claim

Cancel

Exit

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

[Yellow input field]

Last Name

First Name

Middle Name

Name of Supervisor:

SUPERVISOR

JOE

MM-DD-YYYY

Signature of supervisor:

Date signed: 01-20-2005

Supervisor's Title

SUPERVISOR

Supervisor's Email Address:

jsupv@govt.mil

Supervisor's Office phone number

1234567890

39. Filing Instructions

- No lost time and no medical expense: Please
- No lost time, medical expenses incurred
- Lost time covered by leave, LWOP, or C
- First Aid Injury

Select the View Claim button

View Claim

Submit Claim

Cancel

Exit

Window

EDI_CA1

⏪ ⏩ ✕

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

[Redacted text area]

Was an on-site investigation conducted?

Yes

What was the

Name of Supervisor:

Middle Name

Signature of supervisor:

Date signed:

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

Once the View Claim button is selected, a dialog box will open providing two options.

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

view Claim

Submit Claim

Cancel

Exit

Window

EDI_CA1

Window control icons

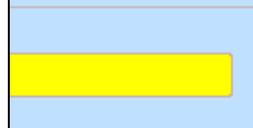
Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

The *View Claim for Printing and Submit to ICPA* option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.

The *View Draft Copy of Claim to Verify Data* option allows the claim to be viewed and printed as a .pdf file but the user must then select the **Submit Claim button to send the claim to the ICPA.**

claim

f my



e Name



MM-DD-YYYY

ed: 04-13-2006

Office phone number

SUPERVISOR

supv@agency.gov

1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

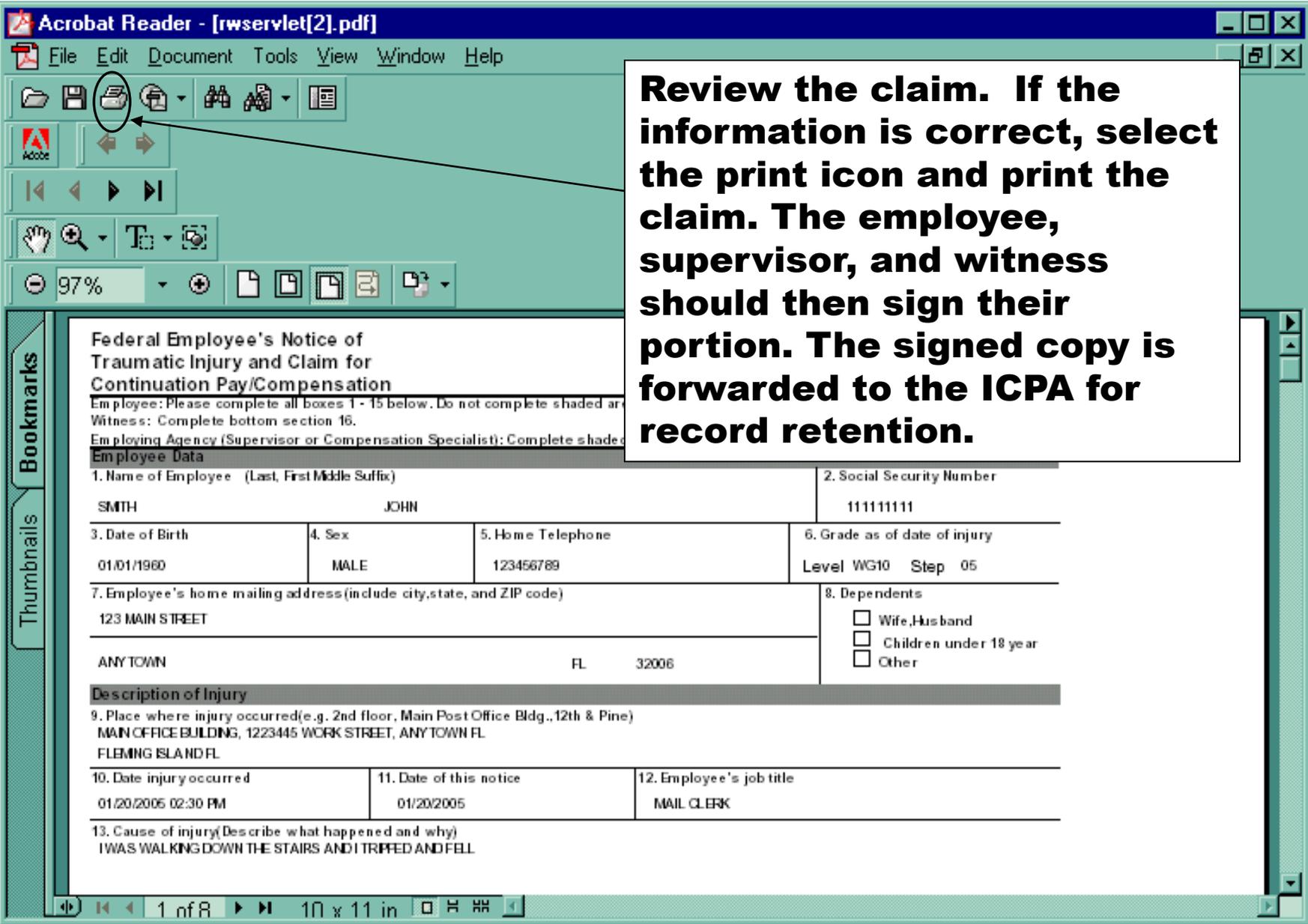
SF-86-D)

view Claim

Submit Claim

Cancel

Exit



Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded areas.

Employee Data

1. Name of Employee (Last, First Middle Suffix) SMITH JOHN		2. Social Security Number 111111111	
3. Date of Birth 01/01/1960	4. Sex MALE	5. Home Telephone 123456789	6. Grade as of date of injury Level WG10 Step 05
7. Employee's home mailing address (include city, state, and ZIP code) 123 MAIN STREET ANYTOWN FL 32006		8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 year <input type="checkbox"/> Other	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL
FLEMING ISLAND FL

10. Date injury occurred 01/20/2005 02:30 PM	11. Date of this notice 01/20/2005	12. Employee's job title MAIL CLERK
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13. Cause of injury (Describe what happened and why)
I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

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

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

Yes No

What was the root cause of this injury?

[Yellow input field]

Last Name
Name of Supervisor: SUPERVISOR

Signature of supervisor: _____

Supervisor's Title
SUPERVISOR

If the *View Draft Copy of Claim to Verify Data* option was selected, the **Submit Claim button must be selected on order to transmit the claim to the **ICPA.****

39. Filing Instructions

- No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- No lost time, medical expenses incurred or expected: forward this form to OWCP
- Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- First Aid Injury

View Claim

Submit Claim

Cancel

Exit

FRM-40400: Transaction complete: 1 records applied and saved.

Record: 1/1

SUMMARY OF SUPERVISOR ACTIONS

- Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page.
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)
- Supervisor enters required information in Supv portion of the form
- The form is printed. The employee, witness and supervisor sign their respective sections.
- “Submit Claim” button is selected and claim is sent electronically to the ICPA.
- Signed claim form is sent to the ICPA to be retained in the file