PROCEDURE 18 - Accident/Illness Reporting and Recording

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Synopsis

This procedure establishes requirements and responsibilities for investigating and recording all occupational injuries, illnesses, equipment/property damage, motor vehicle and near-miss accidents and incidents. The procedure complies with the requirements of 29 CFR 1904, "Recording and Reporting Occupational Injuries and Illnesses" and 29 CFR 1960 Subpart I, "Record Keeping and Reporting Requirements for Federal Employees" and NAO 209-1 NOAA Safety Policy. This procedure applies to all NWS facilities, work locations and employees.

Initial Implementation Requirements:

- **Analyze Site Operations versus Requirements of the Procedure**
- **Develop/Obtain Documentation/Information required for Site**
  - Ensure that all accidents including near misses are reported by supervisors via the NOAA Web Based Safety Incident Reporting System *(18.3.1.a)*
  - Ensure all accidents are fully investigated *(18.3.3)*
  - Ensure availability of required accident/illness reporting forms CA-1, CA-2, CA-16, SF-91, SF-94, etc. (Attachments B-G, OPS1 web site: https://www.ops1.nws.noaa.gov/Secure/SAFETY/EHB-15/Procedures_final/accident_reporting.htm or the NOAA website http://www.seco.noaa.gov - Workers' Compensation screen).
- **Provide Local Training of Site Personnel**
- **Personnel Awareness Training**

Recurring and Annual Task Requirements:

- **Review/Update Documentation/Information required for Site**
  - Maintain records related to incidents and unsafe conditions for 5 years *(18.3.6)*
  - Post annual summary of occupational incidents and illnesses *(18.3.6)*
- **Perform Occupational Injuries Investigation/Corrective Action Determination**
- **Provide Refresher Training of Site Personnel (If Applicable)**

Accident/illness Reporting and Recording Checklist

Requirements	Reference	YES	NO	N/A	Comments
Is initial and annual review of this procedure conducted and documented?	18.4.2				
Are all employees and supervisors aware of on line safety incident/accident reporting procedures?	18.3.1				
Do employees report to their supervisors upon return to work from an occupational accident or illness?	18.3.1c				
Are required worker's compensation forms available for site personnel use?	18.3.2 Attachments B-G				
Are all safety incidents/accidents and near misses investigated and corrective actions taken to preclude recurrence of similar incidents?	18.3.3				
Are all Class A, B, C Mishaps investigated as required?	18.3.3				
Are employees encouraged to orally report unsafe acts, unhealthful working conditions or use Form CD-351, if necessary?	18.3.5				
Are Forms SF-91, SF-94, used to report motor vehicle related incidents? Are they readily available in vehicle glove compartments?	18.3.4				
Is a copy of annual site specific summary of occupational injuries and illnesses (Log 300A) posted from February 1 to April 30?	18.3.6c				

18 ACCIDENT/ILLNESS REPORTING AND RECORDING

18.1 Purpose and Scope

As part of its goal to provide a safe and healthful workplace, the National Weather Service (NWS) has established requirements and responsibilities for the investigation and recording of all occupational injuries, illnesses, equipment/property damage, motor vehicle and near-miss accidents and incidents to comply with the requirements of 29 CFR 1904, "Recording and Reporting Occupational Injuries and Illnesses" and 29 CFR 1960 Subpart I, "Record Keeping and Reporting Requirements for Federal Employees." This procedure applies to all NWS facilities, work locations and employees.

18.2 Definitions

Accident/Incident. An unexpected, unplanned, unwanted event or occurrence which either results in personal injury/illness and/or property damage.

ASC. Administrative Support Center.

Employee. Any person employed or otherwise permitted, or required to work by the NWS.

Field Office. A Field Office may include the following: Weather Forecast Office (WFO), River Forecast Center (RFC), Weather Service Office (WSO), and a Data Collection Office (DCO).

Near Miss. An accident/incident which does not result in personal injury/illness and/or property damage but had the potential to do so and/or a situation in which an inappropriate action occurs or necessary action is omitted, but is detected and corrected before an adverse effect on personnel or equipment results.

Occupational Illness. Any abnormal physical conditions or disorders other than one resulting from an occupational injury caused by exposure to environmental factors which are associated with employment.

Occupational Injury. Any injury such as a cut, fracture, sprain, amputation, etc. which results from a work accident or from a single instantaneous exposure in the work environment.

Operating Unit. For the purpose of this procedure, Operating Unit includes the National Centers for Environmental Prediction (NCEP), National Data Buoy Center (NDBC), NWS Training Center (NWSTC), National Reconditioning Center (NRC), Radar Operations Center (ROC), or the Sterling Field Support Center (SFSC).

OSHA Recordable Injury or Illness. All work-related fatalities, illnesses and those related injuries which result in loss of consciousness, restriction of work or motion, transfer to another job or required medical treatment beyond first aid.

RSM. NOAA Regional Safety Manager (RSM) located at the respective Administrative Support Center (ASC).

Station Manager. For the purpose of this procedure, the Station Manager shall be either the NWS Regional Director; Directors of Centers under NCEP (Aviation Weather Center, NP6; Storm Prediction Center, NP7; and Tropical Prediction Center, NP8); Directors of the NDBC, NWSTC, and Chiefs of NRC, ROC and SFSC facilities; or Meteorologist in Charge (MIC), Hydrologist in Charge (HIC), or Official in Charge (OIC)

18.3 Procedure

18.3.1 Safety Incident/Accident Reporting

When a safety incident/accident occurs, the first priorities are to ensure that the work area is safe in order to prevent injuries to additional personnel and to provide prompt medical assistance to the injured. The affected employee shall immediately report the incident to his/her supervisor. Employees should seek initial treatment for work related illness or injury at health units where available. All job-related safety incidents/accidents, illnesses, near-misses, and property damage/loss must be reported. Any delay in reporting an accident may slow the compensation process. Reporting of near-miss incidents can prevent future occurrences.

a. **All incidents must be reported within 24 hours of occurrence.** If the incident is of a **serious nature**, the reports must be made **within 8 hours.** A serious incident involves
   - 3 or more hospitalizations,
   - fatality, or
   - property damage or loss exceeding $1 million.

The NOAA Web-based Accident/Illness Reporting System shall be used to report all safety incidents/accidents and near misses involving NOAA employees, contractors, and NOAA property. The web site can be accessed via Internet Explorer at:

- http://www.seco.noaa.gov.
- https://ops13web.nws.noaa.gov/accform/acc_info.info_scn

Only NWS supervisory personnel shall enter information into the NOAA web-based Accident/Illness Reporting System. If there is not enough information at the time of report completion, a Follow-Up Information Report (available on the web site) should be filled out as soon as information becomes available.

Incidents include accidents with and without injury (near-miss incidents); all driving accidents while on government business; all property losses including those from fire, ship damage, or environmental spills; and any other incident that results in property damage. Incidents also include any work related illnesses which may involve exposure to chemical, physical (noise, radiation) and biological (bacterial, viral) agents.

b. Paper Form CD-137 “Report of Injury, Illness, Accident, or Fatality” is no longer required and has been replaced by web-based report.

c. Prior returning to work from an occupational injury, accident, or illness, employees shall advise supervisors of their return to work status and of any restrictions or conditions for work.

18.3.2 Workers' Compensation

Many NWS incidents involve treatment by a private physician or an emergency room. NOAA uses the Federal Employees Compensation Act (called "Workers' Compensation" for short) to pay for these services.

All Department of Commerce (DOC) workers' compensation claims processing and liaison services have been provided by a commercial vendor.

To ensure timely claims submission, supervisors send all initial claims (CA-1's and CA-2's), CA-16, and claims for disability compensation (CA-7's) to the address on the website http://www.seco.noaa.gov.

CA-1 and CA-2 forms should also be faxed directly to the Chief, Safety and Health Division, NOAA Safety and Environmental Compliance Office (SECO) at (301) 713-0426.

NOTE:	Workers' Compensation Specialists will provide guidance if additional forms are required.

More information about the DOC Workers' Compensation Program, the Department of Labor Office of Workers' Compensation Program, and electronic forms can be found at OPS1 web site: https://www.ops1.nws.noaa.gov/Secure/SAFETY/EHB-15/Procedures_final/accident_reporting.htm or NOAA SECO web site: http://www.seco.noaa.gov.

a. Department of Labor (DOL) Form CA-1 "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay" (Attachment C). See Attachment H for details.

b. DOL Form CA-2 "Notice of Occupational Disease and Claim for Compensation" (Attachment D). See Attachment H for details.

c. DOL Form CA-16 "Authorization for Examination and/or Treatment" (Attachment G). See Attachment H for details.

18.3.3 Incident/Accident Investigation

Each accident, including near misses, must be investigated to:

- Prevent a recurrence. Accident investigation often brings out "hidden" safety issues that need to be addressed;
- Determine a cause. Determining the cause is not placing blame. Usually accidents have multiple causes and contributing factors;
- Document events and allow proper management of workers' compensation claims; and
- Meet legal requirements for reporting to the Occupational Safety and Health Administration (OSHA).

Requirements for investigation of safety incidents are set by the accident class. NOAA developed a three-tier classification system based on incident/accident severity: Class A, Class B, and Class C Mishaps with Class A being the most serious. See Attachment A for definitions

of the mishap classes.

a. Class A Mishaps require comprehensive investigation. An investigation team will be deployed at the discretion of the Director, NOAA SECO, to investigate and to develop a formal report to senior NOAA executives. Procedures for this type of investigation are outlined in the NOAA Incident Investigation Program Manual, available at http://www.seco.noaa.gov.

b. Class B Mishaps shall be investigated at the regional or national level as appropriate. Regional or National Headquarters management personnel may be directly involved in the investigation process.

c. Class C Mishaps shall be fully investigated by the first or second level supervisor or Station Manager with input from Regional Environmental/Safety Coordinators and NOAA Regional Safety Managers as necessary. As soon as the initial investigation is complete, any immediate dangers will be removed. Appropriate corrective action should be taken to preclude recurrence of similar incidents. The Station manager shall ensure that corrective actions are taken to prevent future recurrences.

The immediate cause of an accident is often operational practices or conditions. Examples of operational practices are: operating without authority, using equipment improperly, not using personal protective equipment when required, not using correct lifting techniques, alcohol or drug use, horseplay, and not properly securing equipment. Examples of conditions are: unserviceable tools and equipment, inadequate warning systems or instructions, bad housekeeping practices, poorly lit work spaces, and unhealthy work environment.

18.3.4 Accident/Incident Resulting in Equipment/Property/Motor Vehicle Damage

All accidents/incidents causing equipment, property, or motor vehicle damage shall be reported on the NOAA Web-based Accident/Illness reporting system as soon as possible. This includes GSA owned, leased, or rented vehicles used by NWS employees; personally owned vehicles if on official duty; and vehicles used by contractors during government related travel. Drivers must report all accidents involving these vehicles within 24 hours and 8 hours if the accident is serious.

Any vehicle accident on public roads shall be investigated by police if feasible. Drivers and supervisors should make every attempt to obtain copies of any police reports. Employee injuries must also be reported using the guidelines outlined in 18.3.1 “Safety Incident/Accident Reporting.” Contractor injuries must be reported by company employees to the contractor’s insurance company.

Form SF-91 “Operator’s Report of Motor Vehicle Accident Report” (Attachment E) and, if appropriate, Form SF-94 “Statement of Witness” (Attachment F) must be completed. Form SF-94 may be used to record witness identity and accident/illness information. Copies of the SF-91, SF-94, vehicle repair estimates, and police reports (if available) must be faxed to the DOC Office of General Counsel (202-482-5858). This allows damage to civilian vehicles or property to be adjudicated.

The following steps should be followed if you are involved in an accident:

a. Stop immediately.
b. Take steps to prevent another accident at the scene.
c. Call a doctor or ambulance if necessary.
d. Notify the police.
e. Do not sign any paper or make any statement as to who was at fault (except to your supervisor or to a Federal government investigator).
f. Get the name and address of each witness. Ask each witness to complete Standard Form 94, Statement of Witness, in the Accident reporting kit (located in the glove compartment).
g. Give the police your name, address, place of employment, and name of your supervisor. Upon request, show your operator's permit and vehicle registration card. (NOTE: Only government-owned or leased vehicles registered in the District of Columbia or displaying state tags have registration cards.)
h. Complete Standard Form 91, Motor Vehicle Accident Report. Notify the Dispatch Pool Manager as soon as possible by calling the telephone number(s) listed in the vehicle's Log Book.
i. If you are unable to reach the Dispatch Pool Manager, call the GSA Maintenance Control Center (888-622-6344).
j. If the vehicle is unsafe to drive and you are unable to contact the Dispatch Pool Manager or the GSA Maintenance Control Center (e.g., due to an accident after normal duty hours) have it towed to the nearest repair shop and contact the Dispatch Pool Manager as soon as possible.

18.3.5 Safety Hazard Reporting

a. Employees are encouraged to orally report unsafe or unhealthful work conditions to their immediate supervisor who shall promptly investigate the situation and take appropriate corrective actions.
b. Supervisors may contact NWS Regional Environmental/Safety Coordinator or NOAA Regional Safety Manager (RSM) for assistance.
c. The employee may submit a written report of unsafe or unhealthful working conditions to Regional/Operating Unit Environmental/Safety Coordinator or RSM using Form CD-351, if employee does not wish to notify supervisor for personal reasons or supervisor fails to take a corrective action within a reasonable time frame (See Attachment B).

NOTE: The CD-351 can also be prepared by Regional headquarters personnel for safety issues impacting all or majority of NWS offices in that Region. The same CD-351 form that is used by individual offices can be used. The Regional CD-351 will be submitted to NWSH for review and evaluation. All remaining Regions will be also involved in review in order to determine if similar safety hazards are present at their respective offices.

d. Regional/Operating Unit Environmental/Safety Coordinator or RSM shall contact originator of report to acknowledge its receipt and discuss the seriousness of the

reported hazard. Supervisor shall be informed the hazard has been reported.

e. Imminent danger situations reported shall be investigated within 24 hours.

f. Potentially serious situations shall be investigated within 3 days.

g. If the reported incident involves a health hazard, the assistance of a competent industrial hygienist shall be requested.

h. The RSM or Environmental/Safety Coordinator must provide a written interim or complete response to the originator of the report within 15 working days of receipt. Interim reports should include the expected date for a complete response.

i. The complete response shall indicate the appropriate channels available for formal appeal (see Chapter 10, paragraph 03 of DOC Safety Manual for additional information related to appeals).

j. Employees involved in a near miss shall report the incident to their supervisor(s) who shall investigate it immediately and report it in NOAA Web-based Accident/Illness Reporting System.

k. The records related to unsafe or unhealthful working conditions or near-miss incidents shall be maintained for five years.

18.3.6 Recording and Recordkeeping

a. All safety incidents/accidents are recorded in the NOAA Web-based Accident/Illness reporting system and in the Microsoft Excel NOAA Safety Information Reporting System (SIRS). An accident report is e-mailed to respective manager(s) on the next day (same day for serious accidents). A cumulative monthly accident report is provided to respective Regional Directors, Operating Unit Directors, and the Deputy Assistant Administrator by NWS Headquarters (NWSH). This monthly report includes OSHA recordable injuries/illnesses rates as well as lost time rates for each regional/operating unit.

b. OSHA Log 300 "Log of Work-Related Injuries" shall be completed by Station Manager or his/her designee for a calendar year and can be filled any time when accident/incident is processed by NOAA SECO and shown on the NWSH monthly accident report. This Log includes names of employees and should be handled as confidential information.

c. Log 300A "Summary of Work-Related Injuries and Illnesses" shall be prepared to record incidents/illnesses for a calendar year by Station Manager or his/her designee. This Log does not include names of employees. It shall be signed by the manager and posted from February 1 to April 30 of the year following the calendar year covered by the summary in a conspicuous place or places where notices to employees are customarily posted. If there were no incident/accidents at the site, the OSHA Log 300A should still be posted with "None" in the incident description block. This Log must be maintained on site and by Regional or Operating Unit Environmental/Safety Coordinators for at least five years.

18.4 Quality Control

18.3.7 Regional and Operating Unit Environmental/Safety Coordinators

a. Shall perform an annual assessment of the regional headquarters facilities or

operating unit to monitor and promote compliance with the requirements of this procedure.

b. Shall perform assessments or designate personnel to perform assessments of all field offices to monitor and promote compliance with the requirements of this procedure every two years.

c. Shall maintain a file of site accident/illnesses reports for at least five years and provide copies of the reports to NWS Safety Officer at NWSH.

18.3.8 Station Manager

Shall review, or delegate review, of this procedure on an annual basis to ensure that the facility is complying with its requirements. Confirmation of this review shall be forwarded to the Regional or Operating Unit Environmental/Safety Coordinator.

18.3.9 NWS Headquarters (NWSH)

a. The NWS Safety Office shall perform an annual assessment of the NWSH facilities to ensure that the facilities are in compliance with this procedure.

b. The NWSH Safety Office shall periodically perform an assessment of the regional headquarters and field offices to ensure compliance with this procedure. The frequency of these regional and field office assessments shall be determined by the NWSH Safety Office.

c. Requests for clarification concerning this procedure shall be directed to the NWSH Safety Office.

18.5 Responsibilities

18.3.10 Regional and Operating Unit Environmental/Safety Coordinators*

Shall monitor and coordinate to promote compliance with the requirements of this procedure for the regional headquarters and field offices or operating units.

18.3.11 Station Manager *

a. Shall have oversight over the implementation of this procedure, and ensure that the requirements of this procedure are followed by individuals at the NWS facility.

b. Shall ensure that annual Log 300 is maintained and Log 300A is posted in accordance with 18.3.6.

c. Shall assure that all accidents/incidents resulted in injury/illness are reported and investigated by supervisors or other designated/authorized personnel.

18.3.12 Supervisor

a. Shall complete Form CA-1, “Federal Employees Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation” items 17 through 38, and obtain witness information (if appropriate, item 16) for completion of Items 17 through 20 (See Attachment C).

b. Shall complete Form CA-2, "Notice of Occupational Disease and Claim for Compensation" items 19 through 35 (See Attachment D).

NOTE: Completed Forms CA-1 and CA-2, shall be send to the address on the website http://www.seco.noaa.gov. Copies should also be faxed directly to the Chief, Safety and Health Division, NOAA Safety and Environmental Compliance Office (SECO) at (301) 713-0426.

c. Shall complete and sign Part A of Form CA-16 "Authorization for Examination and/or Treatment" (See Attachment G).

d. Shall assure that all accidents/incidents resulted in injury/illness or property damage/loss are reported in NOAA Web-based Accident/Illness Reporting System.

18.3.13 Safety or Environmental/Safety Focal Point*

a. Shall ensure that any responsibilities delegated to them by the Station Manager are implemented in accordance with the requirements of this procedure.

b. May be assigned the duties of investigation, recording and reporting as designated by the Station Manager.

c. Shall assist in the investigation and information-gathering of all illnesses/accidents and incidents.

18.3.14 Employees

a. Individual employees affected by this procedure are required to read, understand and comply with the requirements of this procedure.

b. Employees shall report unsafe or unhealthful conditions and practices to their supervisor or safety or environmental/safety focal point. Employees that decided to submit Form CD-351 shall complete items 1 through 8 of the form. Completed form shall be submitted to the Regional or Operating Unit Environmental/Safety Coordinator or NOAA Regional Safety Manager.

c. Employees shall complete items 1 through 15 of Form CA-1 and items 1 through 18 of Form CA-2. Completed forms shall be submitted to the supervisor within six days.

d. Employees shall provide information about medical facility or Physician's office to personnel designated/authorized to complete the Form CA-16, before medical treatment can be obtained (if employee is cognizant and not in a life threatening situation).

NOTE: * - Reference NWS PD 50-11 for complete list of responsibilities http://www.weather.gov/directives/050/pd05011c.pdf

18.6 References

Incorporated References. The following list of references is incorporated as a whole or in part into this procedure. These references can provide additional explanation or guidance for the implementation of this procedure.

18.3.15 U.S. Department of Commerce, Department Administrative Orders Series, Chapter 9, Safety.

18.3.16 US. Department of Commerce Occupational Safety and Health Manual, July 1997, Chapter 11.

18.3.17 U.S. Department of Labor, Occupational Safety and Health Administration, 29 CFR 1904, Recording and Reporting Occupational Injuries and Illnesses.

18.3.18 U.S. Department of Labor, Occupational Safety and Health Administration, 29 CFR 1960, Subpart I: Record Keeping and Reporting Requirements for Federal Employees.

18.3.19 U.S. Department of Labor Reporting Forms:
http://www.dol.gov/esa/regs/compliance/owcp/forms.htm

U.S. Department of Labor, Division of Federal Employees' Compensation Home Page:
http://www.dol.gov/esa/regs/compliance/owcp/fecacont.htm
U.S. Department of Commerce, Office of Human Resource Management:
http://hr.commerce.gov/Employees/WorkLifeIssues/DEV01_006096

18.7 Attachments

Attachment A: Safety Incident Rating Details

Attachment B: U.S. Department of Commerce Form CD-351 "Report of Possible Safety/Health Hazard"

Attachment C: U.S. Department of Labor Form CA-1 "Federal Employees Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation"

Attachment D: U.S. Department of Labor Form CA-2 "Notice of Occupational Disease and Claim for Compensation"

Attachment E: U.S. Department of Labor Form SF-91 "Operator's Report of Motor Vehicle Accident"

Attachment F: U.S. Department of Labor Form SF-94 "Statement of Witness"

Attachment G: U.S. Department of Labor Form CA-16 "Authorization for Examination and/or Treatment"

Attachment H: Summary of Accident/Illness Reporting and Recordkeeping Requirements

ATTACHMENT A
Safety Incident Rating Details Description

Incident Rating Details Description Chart		
Class A Mishap	**Injury to individuals**	• Death from an incident. • 3 or more in-patient hospitalizations within 30 days from an incident. • Incident involving permanent employee disability.
	Dollar loss	• Property damage or loss estimated at greater than $1,000,000.
	Environmental damage	• Release of a listed environmental pollutant in a quantity greater than or equal to the chemicals Reportable Quantity (≥ RQ). • Release of an environmental pollutant outside of the boundaries of a NOAA Facility that requires notification and a clean-up response in accordance with applicable regulations.
	Other	• Incident involving conditions that could pose an imminent and severe threat of serious injury to employees or the environment. ▪ Loss of aircraft while flying. • Any incident elevated from a "Class B Mishap" by request, due to concerns by the investigation authority.
Class B Mishap	**Injury to individuals**	• Any incident, which results in a in-patient stay for an employee. ▪ Incident involving permanent partial disability. • Illness, upon the report of treatment, filing a CA-2, or a report of a suspect illness that will trigger further study.
	Dollar loss	• Property damage or loss estimated at greater than $20,000 but less than $1,000,000.
	Environmental damage	• Release of an environmental pollutant approaching the >RQ.
	Other	• Any Aircraft related incident that forces grounding of the aircraft. • Loss of vessel while underway regardless of size that does not result in a Class A Mishap. • Near miss incidents of nationwide significance reported via NOAA reporting system or CD351 • Any incident elevated from a "Class C Mishap" by request, due to concerns by the investigation authority.
Class C Mishap	**Injury to individuals**	• Any incident, which causes an injury. • Incidents, which involve first aid medical treatment. • Incidents, which result in an employee being taken to a hospital emergency room, without requiring an in-patient, stay.
	Dollar loss	• Property damage or loss up to $20,000.
	Environmental damage	•Unintentional releases of materials to the secondary containment.≤RQ
	Other	• Incidents involving contamination of personnel or environmental exposure by a potentially harmful substance; with no symptoms or circumstances that trigger other mishap classification. • Incidents or exposures that have caused concerns to workers or our customers to include near miss incidents of local significance reported via NOAA reporting system or on CD351. • Close Call Incidents, which had the potential to result in damages, described in the "Class A Mishap" row but do not trigger investigation elsewhere in this table. • All motor vehicle incidents, when investigated by law enforcement officials.

ATTACHMENT B
Form CD-351 "Report of Possible Safety/Health Hazard"

INSTRUCTIONS FOR COMPLETING CD-351

(Report of Possible Safety/Health Hazard)

EMPLOYEE

Supervisors have responsibility for ensuring the safety and well-being of their employees. Therefore, while you have the right to go directly to a safety official, you are encouraged to first contact your supervisor whenever you observe a possible safety or health hazard.

If you do not wish to notify your supervisor for personal reasons or if your supervisor fails to take corrective action within a reasonable time-frame, then you should contact your Area Safety Representative, Operating Unit Safety & Health Representative or Regional Safety Manager.

After notifying the safety official, complete the appropriate section of the CD-351 and submit the form to the safety official notified.

Complete Blocks 1 through 8.

- **Blocks 2 and 3**—Optional under the Privacy Act. However, not providing this information may hinder any investigation since safety personnel will not be able to contact you for additional information nor inform you of any corrective action being taken. (See **Block 5** below.) Include area code or use "999" if FTS in **Block 3**.
- **Block 5**—By indicating "no" to this question, safety personnel may only reveal your name to other safety personnel involved in the investigation. They may not reveal your name to your supervisor or other management Officials.
- **Block 6**—Include operating unit, line organization, name and address of your duty station.
- **Block 7**—Identify specific location (e.g., stairwell, room number, etc.) building number (if appropriate), and address.

Sign (optional) and date form, retain employee's copy, and submit original and other copies to the safety official.

INVESTIGATING SAFETY OFFICIAL

Investigate all reports filed as quickly as possible. (If investigation indicates a life-threatening situation, ASRs should contact appropriate OUSHR or RSM immediately.)

Complete Blocks 9 through 13.

- **Block 11—**Describe interim (if applicable) and permanent corrective action(s) that have or will be taken.
- **Block 12**—Indicate date permanent corrective action was taken (actual) or will be taken (estimate).

After completing form, retain investigator's copy, forward original to appropriate OUSHR/RSM and notification copy to employee (if known).

FORM **CD-351** LF
(REV. 5-89)
DAO 209-4

U.S. DEPARTMENT OF COMMERCE

Case: _____
Date Received: _____
Control: _____
Org. Code: _____

REPORT OF POSSIBLE SAFETY/HEALTH HAZARD

SAFETY & HEALTH MANAGEMENT INFORMATION

TO BE COMPLETED BY EMPLOYEE

1. Reason for Report: ☐ Safety Hazard ☐ Health Hazard

2. Name: _____ (Last, First, M.I.) 3. Phone: _____

4. Have you Reported Condition to Supervisor? ☐ Yes ☐ No

5. May we Reveal Your Name During Investigation? ☐ Yes ☐ No

6. Duty Station Address:

7. Location of Hazard:

8. Description of Hazard:

Signature: _____ Date : _____

TO BE COMPLETED BY INVESTIGATOR

9. Investigation Findings:

10. Life Threatening? ☐ Yes ☐ No

11. Corrective Action:

12. Completion Date : _____ ☐ Estimated ☐ Actual

Investigator's Signature: _____ Date : _____

Title: _____ Phone: _____

ATTACHMENT C
Form CA-1 "Federal Employees Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation"

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

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 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 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 you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

*U.S. GPO: 1999-454-845/12704

Form CA-1
Rev. Apr. 1999

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

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

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 boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle) | 2. Social Security Number

3. Date of birth Mo. Day Yr. | 4. Sex ☐ Male ☐ Female | 5. Home telephone | 6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and ZIP code) | 8. Dependents ☐ Wife, Husband ☐ Children under 18 years ☐ Other

Description of Injury

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

10. Date injury occurred Mo. Day Yr. | Time ☐ a.m. ☐ p.m. | 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation

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

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

a. Occupation code
b. Type code | c. Source code
OWCP Use - NOI Code

Employee Signature

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:

☐ b. 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.

☐ a. 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.

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.

Witness Statement

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

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

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

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

33. First date medical care received Mo. Day Yr.

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ No (If "No," explain)

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

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

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:

Name of supervisor (Type or print)

Signature of supervisor | Date

Supervisor's Title | Office phone

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 expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
☐ First Aid Injury

Form CA-1,

Rev. Apr. 1999

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

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

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury.

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee Is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-1
Rev. Apr. 1999

ATTACHMENT D
Form CA-2 "Notice of Occupational Disease and Claim for Compensation"

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of **2/3** of an employee's salary if there are no dependents, or **3/4** of salary if there are one or more dependents.

An employee may use sick or annual leave rather than LWOP while disabled. The employae may repurchase leave used for approved periods. Form **CA-7b,** available from the personnel office, should be studied BEFORE a decision is made to use leave.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title **20,** Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

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 (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) The 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) The information may also be given to Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and servies. (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. (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.

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

Form CA-2
Rev. Jan. 1997

Notice of Occupational Disease and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a. b. and c.

Employee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth MO. Day Yr.
4. Sex
5. Home telephone ( )
6. Grade as of date of last exposure Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
6. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other

Claim Information

9. Employee's occupation
   a. Occupation code
10. Location (address) where you worked when disease or illness occurred (Include city, State, and ZIP code)
11. Date you first became aware of disease or illness MO. Day Yr.
12. Date you first realized the disease or illness was caused or aggravated by your employment MO. Day Yr.
13. Explain the relationship to your employment, and why you came to this realization
14. Nature of disease or illness
    OWCP Use - NOI Code
    b. Type code | c. Source code
15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with 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 other benefits provided by the Federal Employees' Compensation Act.

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

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

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.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

Form CA-2
Rev. Jan. 1997

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (Include city, state, and ZIP Code) | OWCP Agency Code | OSHA Site Code | ZIP Code

20. Employee's duty station (Street address and ZIP Code) | ZIP Code

21. Regular work hours From: : ☐ a.m. ☐ p.m. To: as : ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)
asdf

24. First dat medical care received asd asd asd

25. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

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

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to 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:

Name of Supervisor (Type or print)

Signature of Supervisor | Date

Supervisor's Title | Office phone

Form CA-2
Rev. Jan. 1997

INSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. In addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. If so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Deailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanations: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness
Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

20. Employee's duty station, street address and ZIP code
The street address and zip code of the establishment where the employee actually works.

24. First date medical care received
The date of the first visit to the physician listed in item 23.

33. Was the injury caused by third party?
A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

19. Agency name and address of reporting office
The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

23. Name and address of physician first providing medical care
The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

32. Employee's Retirement Coverage.
Indicate which retirement system the employee is covered under.

Employing Agency - Required Codes

Box a (Occupational Code), Box b, (Type Code), Box c (Source Code), OSHA Site Code
The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code
This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Form CA-2
Rev. Jan. 1997

ATTACHMENT E
Form SF-91 "Operator's Report of Motor Vehicle Accident"

SECTION XI - ACCIDENT INVESTIGATION DATA

83. DID THE INVESTIGATION DISCLOSE CONFLICTING INFORMATION. ☐ YES ☐ NO *(If "Yes", explain below.)*

84. PERSONS INTERVIEWED

NAME	DATE	NAME	DATE
a.		c.	
b.		d.	

85. ADDITIONAL COMMENTS *(Indicate section and item number for each comment.)*

SECTION XII - ATTACHMENTS

LIST ALL ATTACHMENTS TO THIS REPORT

SECTION XIII - COMMENTS/APPROVAL

86. REVIEWING OFFICIAL'S COMMENTS

87. ACCIDENT INVESTIGATOR	88. ACCIDENT REVIEWING OFFICIAL
a. SIGNATURE AND DATE	a. SIGNATURE AND DATE
b. NAME *(First, middle, last)*	b. NAME *(First, middle, last)*
c. TITLE	c. TITLE
d. OFFICE	d. OFFICE
e. OFFICE TELEPHONE NUMBER	e. OFFICE TELEPHONE NUMBER

STANDARD FORM 91 PAGE 4 (REV. 2-93)

MOTOR VEHICLE ACCIDENT REPORT	Please read the Privacy Act Statement on Page 3.	INSTRUCTIONS: Sections I thru IX are filled out by the vehicle operator. Section X, Items 72 thru 82c are filled out by the operator's supervisor. Sections XI thru XII are filled out by an accident investigator for bodily injury, fatality, and/or damage exceeding $500.

SECTION I - FEDERAL VEHICLE DATA

1. DRIVER'S NAME *(Last, first, middle)*	2. DRIVER'S LICENSE NO./STATE/LIMITATIONS	3. DATE OF ACCIDENT

4a. DEPARTMENT/FEDERAL AGENCY PERMANENT OFFICE ADDRESS	4b. WORK TELEPHONE NUMBER

5. TAG OR IDENTIFICATION NUMBER	6. EST. REPAIR COST	7. YEAR OF VEHICLE	8. MAKE	9. MODEL	10. SEAT BELTS USED
	$				☐ YES ☐ NO

11. DESCRIBE VEHICLE DAMAGE	

SECTION II - OTHER VEHICLE DATA *(Use Section VII if additional space is needed.)*

12. DRIVER'S NAME *(Last, first, middle)*	13. DRIVER'S LICENSE NUMBER/STATE/LIMITATIONS

14a. DRIVER'S WORK ADDRESS	14b. WORK TELEPHONE NUMBER

15a. DRIVER'S HOME ADDRESS	15b. HOME TELEPHONE NUMBER

16. DESCRIBE VEHICLE DAMAGE	17. ESTIMATED REPAIR COST
	$

18. YEAR OF VEHICLE	19. MAKE OF VEHICLE	20. MODEL OF VEHICLE	21. TAG NUMBER AND STATE

22a. DRIVER'S INSURANCE COMPANY NAME AND ADDRESS	22b. POLICY NUMBER
	22c. TELEPHONE NUMBER

23. VEHICLE IS	24a. OWNER'S NAME(S) *(Last, first, middle)*	24b. TELEPHONE NUMBER
☐ CO-OWNED ☐ RENTAL ☐ LEASED ☐ PRIVATELY OWNED		

25. OWNER'S ADDRESS(ES)

SECTION III - KILLED OR INJURED *(Use Section VIII if additional space is needed.)*

A

26. NAME *(Last, first, middle)*	27. SEX	28. DATE OF BIRTH

29. ADDRESS

30. MARK "X" IN TWO APPROPRIATE BOXES			31. IN WHICH VEHICLE	32. LOCATION IN VEHICLE	33. FIRST AID GIVEN BY
☐ KILLED	☐ DRIVER	☐ PASSENGER	☐ FED		
☐ INJURED	☐ HELPER	☐ PEDESTRIAN	☐ OTHER (2)		

34. TRANSPORTED BY	35. TRANSPORTED TO

B

36. NAME *(Last, first, middle)*	37. SEX	38. DATE OF BIRTH

39. ADDRESS

40. MARK "X" IN TWO APPROPRIATE BOXES			41. IN WHICH VEHICLE	42. LOCATION IN VEHICLE	43. FIRST AID GIVEN BY
☐ KILLED	☐ DRIVER	☐ PASSENGER	☐ FED		
☐ INJURED	☐ HELPER	☐ PEDESTRIAN	☐ OTHER (2)		

44. TRANSPORTED BY	45. TRANSPORTED TO

46. Pedestrian

a. NAME OF STREET OR HIGHWAY	b. DIRECTION OF PEDESTRIAN *(SW corner to NE corner, etc.)*	
	FROM	TO

c. DESCRIBE WHAT PEDESTRIAN WAS DOING AT TIME OF ACCIDENT (Crossing intersection with signal, against signal, diagonally, in roadway playing, walking, hitchhiking, etc.)

Previous edition not usable

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STANDARD FORM 91 PAGE 1 (REV. 2-93)
Prescribed by GSA - FPMR 101-38.6

Clear Form

SECTION IV - ACCIDENT TIME AND LOCATION *(Use Section VIII if additional space is needed.)*

47. DATE OF ACCIDENT	48. PLACE OF ACCIDENT *(Street address, city, state, ZIP Code; Nearest landmark; Distance nearest intersection; Kind of locality (industrial, business, residential, open country, etc.); Road description).*
49. TIME OF ACCIDENT AM PM	

50. INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED

Use one of these outlines to sketch the scene. Write in street or highway names or numbers.

a. *Number Federal vehicle as 1, other vehicle as 2, additional vehicle as 3 and show direction of travel with arrow.*

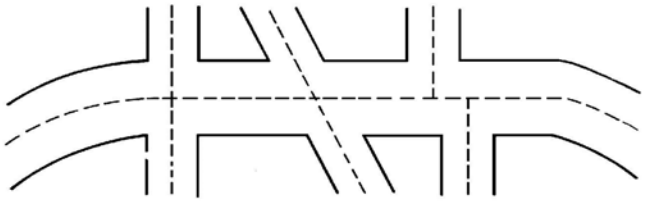
Example: → 1 2 ←

b. Use solid line to show path before accident → 2 and broken line after the accident ····· 2

c. Show pedestrian by →○

d. Show railroad by ++++++++

e. Place arrow in this circle to indicate *NORTH* ○



51. POINT OF IMPACT *(Check one for each vehicle)*

FED	2	AREA
		a. FRONT
		b. R. FRONT
		c. L. FRONT
		d. REAR
		e. R. REAR
		f. L. REAR
		g. R. SIDE
		h. L. SIDE

52. DESCRIBE WHAT HAPPENED *(Refer to vehicles as "Fed", "2", "3", etc. Please include information on posted speed limit, approximate speed of the vehicles, road conditions, weather conditions, driver visibility, condition of accident vehicles, traffic controls (warning light, stop signal, etc.) condition of light (daylight, dusk, night, dawn, artificial light, etc.) and driver actions (making U-turn, passing, stopped in traffic, etc.).*

SECTION V - WITNESS/PASSENGER *(Witness must fill out SF 94, Statement of Witness) (Continue in Section VIII.)*

A	53. NAME *(Last, first, middle)*	54. WORK TELEPHONE NUMBER	55. HOME TELEPHONE NUMBER
	56. BUSINESS ADDRESS	57. HOME ADDRESS	
B	58. NAME *(Last, first, middle)*	59. WORK TELEPHONE NUMBER	60. HOME TELEPHONE NUMBER
	61. BUSINESS ADDRESS	62. HOME ADDRESS	

SECTION VI - PROPERTY DAMAGE *(Use Section VIII if additional space is needed.)*

63a. NAME OF OWNER	63b. OFFICE TELEPHONE NUMBER	63c. HOME TELEPHONE NUMBER
63d. BUSINESS ADDRESS	63e. HOME ADDRESS	
64a. NAME OF INSURANCE COMPANY	64b. TELEPHONE NUMBER	64c. POLICY NUMBER

65. ITEM DAMAGED	66. LOCATION OF DAMAGED ITEM	67. ESTIMATED COST $

SECTION VII - POLICE INFORMATION

68a. NAME OF POLICE OFFICER	68b. BADGE NUMBER	68c. TELEPHONE NUMBER
69. PRECINCT OR HEADQUARTERS	70a. PERSON CHARGED WITH ACCIDENT	70b. VIOLATION(S)

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SECTION VIII - EXTRA DETAILS

SPACE FOR DETAILED ANSWERS. INDICATE SECTION AND ITEM NUMBER FOR EACH ANSWER. IF MORE SPACE IS NEEDED, CONTINUE ITEMS ON PLAIN BOND PAPER.

SECTION IX - FEDERAL DRIVER CERTIFICATION

In compliance with the Privacy Act of 1974, solicitation of the information requested on this form is authorized by Title 40 U.S.C. Section 491. Disclosure of the information by a Federal employee is mandatory as the first step in the Government's investigation of a motor vehicle accident. The principal purposes for using this information is to provide necessary data for legal counsel in legal actions resulting from the accident and to provide accident information/statistics in analyzing accident causes and developing methods of reducing accidents. Routine use of information may be by Federal, State or local governments, or agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions. An employee of a Federal agency who fails to report accurately a motor vehicle accident involving a Federal vehicle or who refuses to cooperate in the investigation of an accident may be subject to administrative sanctions.

I certify that the information on this form *(Sections I thru VIII)* is correct to the best of my knowledge and belief.

71a. NAME AND TITLE OF DRIVER	71b.. DRIVER'S SIGNATURE AND DATE

SECTION X - DETAILS OF TRIP DURING WHICH ACCIDENT OCCURRED

72. ORIGIN	73. DESTINATION

74. EXACT PURPOSE OF TRIP

	DATE	TIME *(Circle one)*		DATE	TIME *(Circle one)*
75. TRIP BEGAN		a.m. p.m.	76. ACCIDENT OCCURRED		a.m. p.m.

77. AUTHORITY FOR THE TRIP WAS GIVEN TO THE OPERATOR	78. WAS THERE ANY DEVIATION FROM DIRECT ROUTE
☐ ORALLY ☐ IN WRITING *(Explain)*	☐ NO ☐ YES *(Explain)*
79. WAS THE TRIP MADE WITHIN ESTABLISHED WORKING HOURS	80. DID THE OPERATOR, WHILE ENROUTE, ENGAGE IN ANY ACTIVITY OTHER THAN THAT FOR WHICH THE TRIP WAS AUTHORIZED.
☐ YES ☐ NO *(Explain)*	☐ NO ☐ YES *(Explain)*

81. COMPLETED BY DRIVER'S SUPERVISOR	a. DID THIS ACCIDENT OCCUR WITHIN THE EMPLOYEE'S SCOPE OF DUTY	b. COMMENTS
	☐ YES ☐ NO	

82a. NAME AND TITLE OF SUPERVISOR	82b. SUPERVISOR'S SIGNATURE AND DATE	82c. TELEPHONE NUMBER

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ATTACHMENT F
Form SF-94 "Statement of Witness"

STATEMENT OF WITNESS *(Attach additonal sheets if necessary)*	1. DID YOU SEE THE ACCIDENT?	2. WHEN DID THE ACCIDENT HAPPEN? A. TIME — a.m. p.m.	B. DATE

3. WHERE DID THE ACCIDENT HAPPEN? *(Give street location and city)*

4. TELL IN YOUR OWN WAY HOW THE ACCIDENT HAPPENED

5. WHERE WERE YOU WHEN THE ACCIDENT OCCURRED?

6. WAS ANYONE INJURED, AND IF SO, EXTENT OF INJURY IF KNOWN?

7. DESCRIBE THE APPARENT DAMAGE TO PRIVATE PROPERTY

8. DESCRIBE THE APPARENT DAMAGE TO GOVERNMENT PROPERTY	9. IF TRAFFIC CASE GIVE APPROXIMATE SPEED OF: a. GOVERNMENT VEHICLE MPH b. OTHER VEHICLE MPH

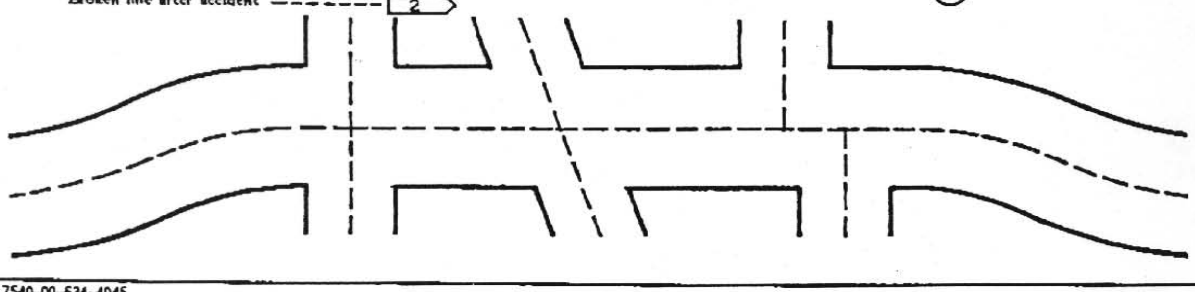
10. GIVE THE NAMES AND ADDRESSES OF ANY OTHER WITNESSES TO THE ACCIDENT *(If known)*

A. NAMES	B. ADDRESSES

WITNESS COMPLETING THIS FORM	11. HOME ADDRESS *(INCLUDE ZIP CODE)*	12. WITNESS (PRINT OR TYPE NAME)	A. HOME TELEPHONE NO.
		SIGN HERE ☛	B. TODAY'S DATE
13. BUSINESS ADDRESS *(INCLUDE ZIP CODE)*			TELEPHONE NO.

14. INDICATE ON THE DIAGRAM BELOW WHAT HAPPENED:

1. Number Federal vehicle as 1—other vehicle as 2—additional vehicle as 3, and show direction of travel by arrow (*Example:* → 1 2 ←)
2. Use solid line to show path before accident → 2
   Broken line after accident - - - → 2
3. Show pedestrian by ——→ O
4. Show railroad by +++++++++++++++++
5. Give names or numbers of streets or highways
6. Indicate north by arrow in this circle ◯



NSN 7540-00-634-4045
94-105

STANDARD FORM 94 (REV. 2-8

ATTACHMENT G
Form CA-16 "Authorization for Examination and/or Treatment"

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 any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. ICD-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is your diagnosis?

18a. ICD-9 Code

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt.)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ 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 First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. 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.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If Yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, Zip Code)

37. Tax Identification Number

38. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
*U.S. Government Printing Office: 1990-261-871/11410

Authorization for Examination
And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The following request for information is authorized by law (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 09-30-91

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)	3. Date of Injury (mo., day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of the injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the Employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advice the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official:
	9. Name and Title of Authorizing Official: (Type or print clearly)
10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
12. Send one copy of your report: (Fill in remainder of address) **U.S. DEPARTMENT OF LABOR** Employment Standards Administration Office of Workers' Compensation Programs	13. Name and Address of Employee's Place of Employment: Department or Agency Bureau or Office Local Address (Including Zip Code)

Public Burden Statement

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 and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing burden, to the Office of Information Management, Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

This form was electronically produced by National Production Services Staff

Clear Form

Form CA-16
Rev. Oct. 1988

ATTACHMENT H
Summary of Accident/illness Reporting and Recordkeeping Requirements

Form Type	Applicability	When Completed	Completed By	Where Submitted	Reporting/Recordkeeping
CD-351, Report of Possible Safety/Health Hazard (DOC)	The form should be used to report possible safety and health hazards if employee does not wish to notify supervisor for personal reasons or supervisor fails to take corrective action within a reasonable time frame.	The form may be completed any time.	Blocks 1-8 shall be completed by employee. Blocks 8-13 shall be completed by investigating safety official (the RSM or Regional Coordinator)	Submit to Regional Coordinator or NOAA RSM.	A written interim or complete response shall be provided by Regional Coordinator or RSM within 15 working days of the receipt of the report. The CD-351 reports shall be maintained for 5 years on site.
CA-1, Federal Employees Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation (DOL)	The form shall be completed to obtain continuation of pay benefit for disability resulting from traumatic job-related injury.	Form must be filed within 30 days following the injury. To avoid possible interruption of pay, form should be filed within two working days	Employee or someone acting on his/her behalf shall complete items 1-15. Item 16 is completed by a witness Supervisor or Compensation Specialist completes items 17-38	CA-1 should be forwarded by Supervisor or Compensation Specialist to the DOC Worker's Compensation Operations Center.	The form must be submitted to the address on the website http://www.seco.noaa.gov. It should also be faxed directly to the Chief, Safety and Health Division, NOAA Safety and Environmental Compliance Office (SECO) at (301) 713-0426.
CA-2, Notice of Occupational Disease and Claim for Compensation (DOL)	The form shall be completed by employee who intends to claim compensation related to occupational disease.	When disease is diagnosed by a medical professional	Employee must complete items 1-18. Supervisor completes items 19-35.	CA-2 should be submitted to the address on the website http://www.seco.noaa.gov. It should also be faxed directly to the Chief, Safety and Health Division, NOAA Safety and Environmental Compliance Office (SECO) at (301) 713-0426.	When disability does not result in time loss, medical expenses or anticipated disability, the CA-2 should be retained as a part of the Employee's Medical File. Narratives prepared by employee and supervisor should be also submitted within 30 days.
CA-16, Authorization for Examination and/or Treatment (DOL)	The form is used to authorize initial medical treatment in traumatic injury cases.	The form must be available within four hours after a request is made for	Station Manager or other Authorizing official fills out Part A - Authorization	CA-16 is submitted to DOC Worker's Compensation Operations Center to the address on the website	Hospital and related medical bills should be submitted to DOC Worker's Compensation Operations Center.

Form Type	Applicability	When Completed	Completed By	Where Submitted	Reporting/Recordkeeping
(DOL)	All disease cases must be approved by DOC Worker's Compensation Operations Center before CA-16 is issued. The name of the person who approved issuing of authorization must be recorded in item 7 of the form.	medical treatment of traumatic injury. Where emergency treatment was received, the form must be issued within 48 hours after treatment.	Part B is filled out by Attending Physician. Note: Agency may refuse to issue CA-16 if more than a week passed since the injury.	http://www.seco.noaa.gov.	Note: Medical bills are guaranteed to be paid for up to 60 days or until OWCP withdraws authorization.
SF-91, Operator's Report of Motor Vehicle Accident (DOL)	The form shall be filled out in case of a motor vehicle accident resulting in equipment, property and motor vehicle damage.	As soon as accident occurred.	Section I-IX shall be completed by employee involved in the accident Section X is completed by employee's supervisor Sections XI-XIII are completed by an accident investigator for bodily injury, fatality and/or damage exceeding $500.	If GSA vehicle is involved in the accident, a copy of the form should be submitted to GSA in accordance with instructions shown in the vehicle packet. Copy of the SF-91, vehicle repair estimates, and police reports (if available) must be faxed to the DOC Office of General Counsel (202-482-5858)	The reports must be retained in the office and at ASC.
SF-94, Statement of Witness (DOL)	The form should be filled out if there is a witness of motor vehicle accident resulted in equipment, property and motor vehicle damage.	After accident occurred.	Witness of the accident	Copy of the SF-94, vehicle repair estimates, and police reports (if available) must be faxed to the DOC Office of General Counsel (202-482-5858)	The reports must be retained in the office and at ASC.