

Notice of Recurrence



Employee: Complete Part A below.

Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

OMB No. 1215-0167
 Expires: 05-31-02

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

Part A - Employee

1. Name of employee (Last, First, Middle)	2. Social Security Number	3. OWCP file number for original injury
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4. Date of birth Mo. Day Yr. 	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Home telephone ()
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7. Home mailing address (include city, state, and ZIP code)	8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other
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9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)	10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
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11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work after recurrence (mo., day, year)	14. Date and Hour pay stopped after recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
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<input type="checkbox"/> Medical Treatment Only <input type="checkbox"/> Time Loss From Work	17. Date of first medical treatment following recurrence (mo., day, year)	18. Name and address of treating physician
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19. After returning to work following the original injury, were you in any way limited in performing your usual duties? Yes No
 (If so, explain. Also state how long these limitations continued.)

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical 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 Federal Employees' Compensation Act (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.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.
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.
I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee	24. Date (mo., day, year)
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Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

4. What was your rate of pay if you stopped work due to this recurrence?

\$ _____ per _____

5. Do you claim compensation for lost wages? Yes No

If so, for what period? _____ through _____

6. Have you received any pay during the period claimed? Yes No

If so, how much and from what source? _____

Section 8101, et seq., Title 5 to the U.S. Code authorizes collection of this information. Completion of this form is mandatory in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee

8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A Recurrence of the Medical Condition is the documented need for additional medical treatment after release from treatment for the work-related injury. Continuing treatment for the original condition is not considered a recurrence.

A Recurrence of Disability is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used,