Attending Physician's Supplemental Report

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

For Instructions See Reverse Side

OMB No. 1215-0103
Expires: 10-31-99

1. Name of injured employee (Last, first, middle)

2. OWCP File Number, if known

3. Home mailing address (Include Zip code)

4. Social Security Number

5. Date and hour of injury (Mo., day, year)
☐ AM
☐ PM

6. Period compensation is claimed as a result of pay loss (Mo., day, year)
From: Through:

7. Date of most recent examination (Mo., day, year)

8. Is employee's present condition due to the injury for which compensation is claimed?
☐ Yes ☐ No

9. Is employee totally disabled for usual work?
☐ Yes ☐ No

10. Describe nature of present impairment

11. State diagnosis

11a. ICD-9 Code

12. What treatment is employee receiving and how often is it given?

13. What permanent effects, if any, are anticipated?

14. Describe any concurrent disability employee has which is not related to this injury

15. Will disability for regular work continue for 90 days or longer?
☐ Yes ☐ No
If no, approximately what date will employee be able to return to work? (Mo., day, year)

16. If employee is able to resume regular work, has he or she been advised? ☐ Yes ☐ No
If Yes, show date employee was informed (Mo., day, year)

17. If employee is only partially disabled, show date he or she was able to perform some work and describe specific work restrictions. (i.e. limitations in stooping, bending, lifting, etc.)

18. If employee has been referred to another physician for consultation or treatment, give physician's name & address.

19. Recommendations and Prognosis

20. Address (Include Zip code)

21. If you specialize, indicate specialty

22. Signature of Physician. I certify that the statements on the reverse apply to this report and are made a part hereof.

23. Date of Report (Mo., day, year)

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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

Form CA-20a
Rev. Jan. 1997

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT:

A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20a.

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

1. Complete the entries 7-23 on this report (and items 1-6 if not previously completed), and
2. Forward the report directly by mail to the OWCP office indicated below
3.

OFFICE OF WORKERS' COMPENSATION PROGRAMS

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The requested information is required to obtain or retain a benefit in accordance with The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) which is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is required by P.L. 103-296 108 Stat. 1464. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

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