



FOR INSTRUCTIONS SEE REVERSE SIDE	
1. NAME OF INJURED EMPLOYEE (<i>Last, first, middle</i>)	2. OWCP FILE NUMBER, IF KNOWN
3. HOME MAILING ADDRESS (<i>Include ZIP code</i>)	4. SOCIAL SECURITY NUMBER
5. DATE AND HOUR OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM	6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS <i>(Mo., day, year)</i> FROM: _____ THROUGH: _____
7. DATE OF MOST RECENT EXAMINATION <i>(Mo., day, year)</i>	8. IS EMPLOYEE'S PRESENT CONDITION DUE TO THE INJURY FOR WHICH COMPENSATION IS CLAIMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
	9. IS EMPLOYEE TOTALLY DISABLED FOR USUAL WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
10. DESCRIBE NATURE OF PRESENT IMPAIRMENT	11. STATE DIAGNOSIS
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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, APPROXIMATELY WHAT DATE WILL EMPLOYEE BE ABLE TO RETURN TO WORK? (<i>Mo., day, year</i>)	16. IF EMPLOYEE IS ABLE TO RESUME REGULAR WORK, HAS HE OR SHE BEEN ADVISED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SHOW DATE EMPLOYEE WAS INFORMED (<i>Mo., day, year</i>)
17. IF EMPLOYEE IS ONLY PARTIALLY DISABLED, SHOW DATE HE OR SHE WAS ABLE TO PERFORM SOME WORK AND DESCRIBE SPECIFIC WORK RESTRICTIONS. (<i>i.e. limitations in stooping, bending, lifting, etc.</i>)	18. IF EMPLOYEE HAS BEEN REFERRED TO ANOTHER PHYSICIAN FOR CONSULTATION OR TREATMENT, GIVE PHYSICIAN'S NAME & ADDRESS.
19. RECOMMENDATIONS AND PROGNOSIS	
20. ADDRESS (<i>Include ZIP code</i>)	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 (<i>Mo., day, year</i>)

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, CA-20 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 c and

- 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), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) 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 immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or have complied with the provisions of 20 CFR 10. (4) 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 is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).