OWCP Form CA-17 Instructions

Summary

Purpose

To keep the ICCO and the OWCP office informed of the injured or ill employee's ability to return to either limited or full duty.

Prepared By

1. SIDE A.
   a. For initial disability: direct supervisor.
   b. For continuing full or partial disability: ICCO
2. SIDE B: Treating Physician

When to Prepare

1. After initial injury to accompany the CA-16.
2. For continuing total disability for each medical visit; or at a minimum of each two weeks.
3. For continuing limited duty or follow up examinations when employee has returned to duty.

General Procedures

1. The appropriate official completes Side A
2. The employee delivers this form, along with the CA-16, job descriptions, and OWCP Form 1500 as appropriate, to the treating physician.
3. The treating physician will complete Side B of the form and either give it, along with the approved job descriptions, to the employee for immediate return to the ICCO or, if necessary, mail to the ICCO in the envelope provided.

Filing and Distribution

Filing and distribution procedures are as follows:

1. ICCO will forward the *original* of the form to OWCP (**Note**: the form instructions state to send a copy to OWCP, however the USPS policy is to send the original CA-17 to OWCP)
2. Keep a *copy* in the Injury Compensation file.

OWCP Form CA-17 Instructions (continued)

Instructions

Side A is to be completed by the immediate supervisor/control office/point.

1. Claimant's complete name; last name, first name, and middle name.

   (Enter "NMN" if no middle name)

2. Date of injury; Item 10 or 21 on the CA-1 or Item 29 on the CA-2.
3. SSN consists of NINE digits.
4. Occupation (employee's title).
5. Brief description of injury or illness and part(s) of body affected. Refer to Item 13 and 14 on the CA-1 or Item 14 on the CA-2.
6. Work schedule
7. Complete as accurately as possible based on the work the employee *actually* performs in his or her *regular assignment.*

   Note: The attending physician completes Side B. A physician's assistant, nurse practitioner, nurse, or other person not within the FECA definition of a physician is not acceptable as the certifying physician. Certification by a physician's assistant will be acceptable if such certification is countersigned by a physician.

OWCP Form CA-17

Duty Status Report

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

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.). Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

OMB No. 1215-0103
Expires: 10-31-94

OWCP File Number (If known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)

2. Date of Injury (Month, day, yr.) | 3. Social Security No.

4. Occupation

5. Describe How the Injury Occurred and State Parts of the Body Affected

6. The Employee Works
Hours Per Day Days Per Week

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day
b. Sitting			Hrs Per Day
c. Standing			Hrs Per Day
d. Walking			Hrs Per Day
e. Climbing			Hrs Per Day
f. Kneeling			Hrs Per Day
g. Bending/Stooping			Hrs Per Day
h. Twisting			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day
j. Simple Grasping			Hrs Per Day
k. Fine Manipulation (includes keyboarding)			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day
o. Temp. Extremes			range in degrees F
p. High Humidity			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
r. Fumes/Dust (identify)			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day
t. Other (Describe)			

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis Due to Injury | 11. Other Disabling Conditions

12. Employee Advised to Resume Work?
☐ Yes, Date Advised ___/___/___ ☐ No

13. Employee Able to Perform Regular Work Described on Side A?
☐ Yes, If so ☐ Full-Time or ☐ Part-Time _____ Hrs Per Day
☐ No, If not, complete below:

Continuous	Intermittent	
#lbs.	#lbs.	Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		range in degrees F
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination | 16. Date of Next Appointment

17. Specialty | 18. Tax Identification Number

19. Physician's Signature | 20. Date

OWCP Form CA-17 (continued)

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 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-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

Form CA-17
Rev. July 1991

For sale by the Superintendent of Documents, U[illegible]overnment Printing Office, Washington, D.C. 20402