27 February 1953

OPM 20-620-1

PERSONNEL DIRECTOR MEMORANDUM NO. 12-53

SUBJECT: Interim Instruction - Compensation for Injury or Death

1. The attached interim instruction on compensation for injury or death incurred in the performance of duty is issued pending publication of an Agency Regulation on this subject. This is the first of a series of such instructions to be published in the next few weeks. Internal procedures of the Personnel Office will conform to those instructions immediately upon issuance. Upon publication as an Agency Regulation the attached material will supersede the present CIA Regulation [redacted] 25X1A

2. Information copies of this instruction will be distributed to other interested offices of the Agency. Comments or suggestions of these offices are invited in order that they may be considered in the preparation of the Regulation. Offices receiving information copies are being asked to forward their comments to the Personnel Office, attn: Research and Planning Staff, by 23 March 1953. 25X1A

[redacted]

GEORGE E. MELOON
Personnel Director

[redacted]

Revd by 5-130-4 (27-55)
20 Jul 55

INTERIM INSTRUCTION — PERSONNEL

Compensation for Injury or Death

1. Policy

Employees of the Central Intelligence Agency are entitled to compensation benefits under the Federal Employees' Compensation Act (Public Law 267, 64th Congress) as amended and/or the Central Intelligence Agency Act of 1949 (Public Law 110, 81st Congress) as amended. These benefits include compensation for disability and death, and medical care for employees who suffer injuries in the performance of their duties.

2. Definitions

a. "In the Performance of Duty"

"In the performance of duty", as used in this Instruction, means that the individual's injury is directly attributable to or materially aggravated by his work and is not the result of the employee's willful misconduct, intoxication, or intention to bring about the injury or death of himself or another.

b. "Injury"

For the purposes of this Instruction, the term "injury" includes, in addition to injury by accident, any disease proximately caused by the employment of the individual.

3. Coverage

a. Federal Employees' Compensation Act

(1) The provisions of the Federal Employees' Compensation Act apply to employees of the Central Intelligence Agency who are citizens or residents of the United States or a territory of the United States.

(2) Employees of the Central Intelligence Agency who are neither citizens nor residents of the United States nor a territory of the United States will be compensated substantially in accordance with the benefit provisions of local workmen's compensation laws and regulations as recognized by the United States Bureau of Employees' Compensation.

b. Central Intelligence Agency Act of 1949

Employees otherwise eligible for benefits under the Federal Compensation Act whose claims may not be submitted to the Bureau of Employees'

INFORMATION

Compensation for security reasons will be granted these benefits under the authority contained in Section 10 of the Central Intelligence Agency Act of 1949.

4. Responsibilities

a. The Assistant Director (Personnel) is responsible for the administration of this program, for prescribing necessary procedures and for coordinating activities of other offices responsible for the performance of related functions. He, or his designee, will determine whether claims are to be processed under the provisions of the Federal Employees' Compensation Act or the Central Intelligence Agency Act and will administratively approve or disapprove those processed under the latter Act.

b. The Office Chief concerned, the Chief, Medical Staff, the General Counsel and the Security Officer, CIA, are responsible for providing such recommendations concerning medical, legal or security issues involved in determining the method of processing or the compensability of individual claims as are requested by the Assistant Director (Personnel), or his designee.

c. Supervisory officials are responsible for furnishing such documents, records and information as may be requested.

d. Employees who claim benefits are responsible for complying with the procedural requirements set forth below and for fulfilling such other requests for information and examinations as may be necessary.

5. Benefits

a. General

Information and advice as to benefits in specific cases will be provided by the Personnel Office upon request. The general benefits to which employees may be entitled are listed in Appendix A. Briefly they include the following:

(1) Payment for medical services and supplies, regardless of whether the injury has resulted in loss of worktime.

(2) Loss of income benefits based upon time lost from work and upon the nature of disability or disfigurement.

(3) Allowance for the services of an attendant for totally disabled persons.

(4) Allowance for vocational rehabilitation of permanently disabled persons.

(5) Death benefits based on the employee's monthly pay and the number and relationship of his dependents.

(6) Allowance for funeral expenses, under certain circumstances.

b. Waiting Period

Employees are not entitled to compensation for loss of pay for the first three days of disability unless the period of disability exceeds 21 days or is permanent.

c. Use of Sick or Annual Leave

If the employee so elects, sick and/or annual leave or leave without pay may be utilized during the period of disability. In such cases, compensation payments will become effective upon termination of leave.

d. Alternative Benefits

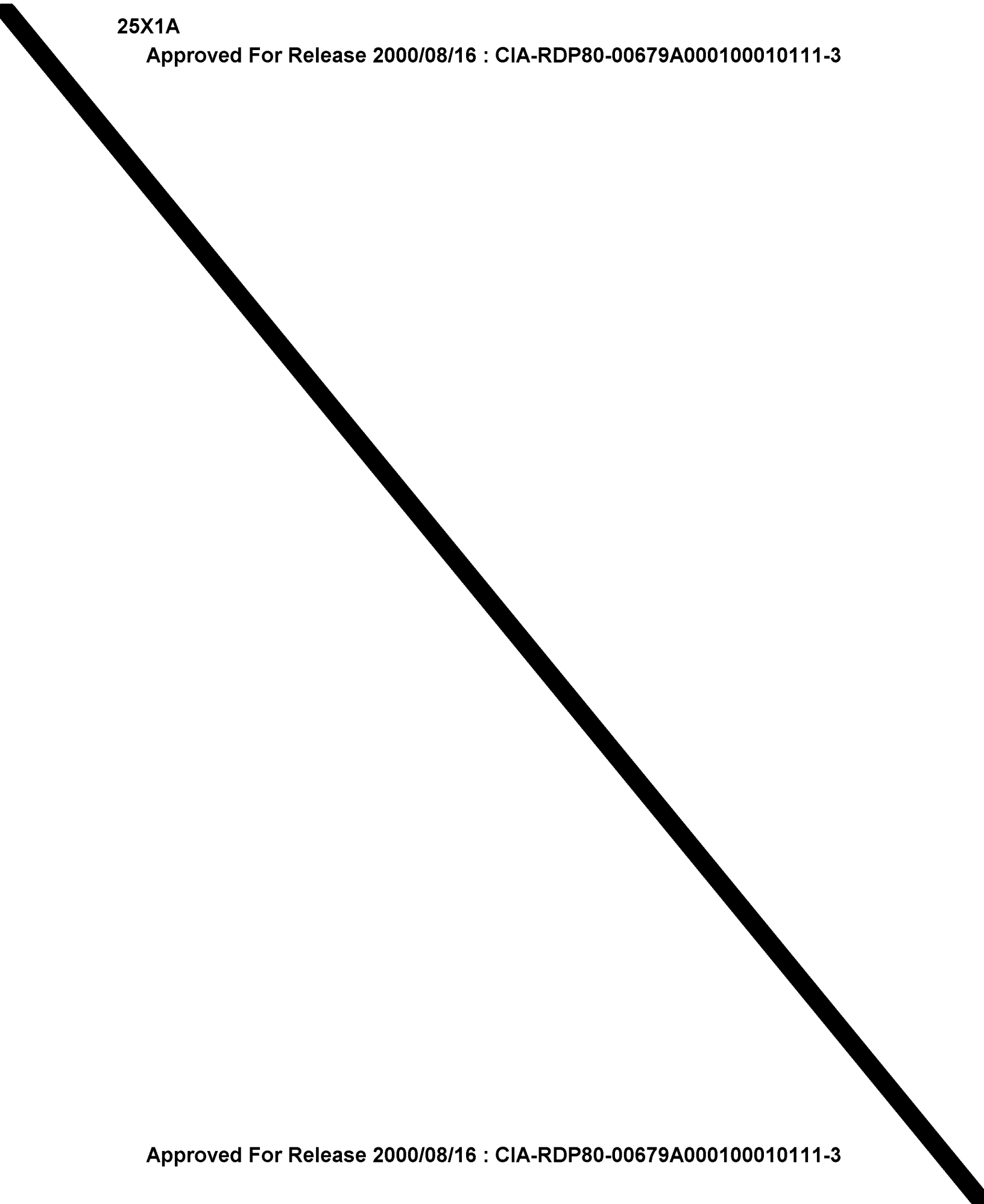
An employee who is entitled to compensation benefits under the Federal Employees' Compensation Act, as amended, or the CIA Act, as applicable, may also qualify for other benefits. For example, an employee eligible for compensation benefits may also be eligible for a disability annuity under the Civil Service Retirement Act. An employee who is eligible for alternative benefits shall elect which of the benefits he will receive for the period the benefits are available.

6. Treatment

a. Medical treatment of an employee injured in the performance of duty will be arranged by his supervisor as follows:

(1) Personnel stationed in Washington will be referred to the Agency Medical Office.

(2) Personnel of a U. S. field station outside Washington will be referred to the local CIA medical officer, if one is available. Otherwise, if security considerations permit, they will be referred to the nearest U. S. Government medical facility or physician designated by the Bureau of Employees' Compensation, when available. If neither a local CIA medical officer nor a U. S. Government medical facility nor a designated physician can be used, the Chief, Medical Staff, will be contacted for instructions or, in an emergency case, treatment may be obtained



b. Any injury incurred in the performance of duty which disables or is likely to disable an employee will be reported by the supervisor of the employee concerned on Form C. A. 2, Official Superior's Report of Injury. (Sample copy of Form C. A. 2 is included in Appendix B.) This form will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels. When treatment has not been furnished by the Agency Medical Office, the supervisor will arrange for completion of the Government Medical Officer's statement on the reverse side of Form C. A. 2, if applicable, unless security considerations preclude furnishing this information.

c. Termination of disability of an injured employee will be reported by his supervisor on Form C. A. 3 (upper portion), Report of Termination of Total or Partial Disability, unless it has previously been reported on Form C. A. 2, Official Superior's Report of Injury. Form C. A. 3 will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels.

d. Death of an employee as a result of an injury incurred in the performance of duty will be promptly reported by the employee's supervisor on Form C. A. 3 (lower portion), Report of Death. Form C. A. 3 will be prepared in duplicate and forwarded to the Personnel Office through appropriate administrative channels.

8. Claims

a. An employee injured in the performance of duty will make claim for reimbursement or payment of the cost of medical services and supplies and for compensation for loss of pay on Form C. A. 4, Claim for Compensation on Account of Injury. (Sample copy of Form C. A. 4 is included in Appendix B.) Form C. A. 4 will be prepared in duplicate within 60 days from the date of injury. Documents in support of the claim, including all itemized bills and receipts, travel orders and claims for personal expenditures by the individual, will accompany Form C. A. 4. The Attending Physician's Certificate on the reverse side of Form C. A. 4 will be obtained if security considerations permit. The supervisor of the injured employee will complete the Certificate of Official Superior of Injured Employee on the reverse side of Form C. A. 4. Completed forms will be forwarded to the Personnel Office through appropriate administrative channels.

b. Claim for compensation benefits by the survivor(s) of an employee who dies as the result of an injury incurred in the performance of duty will be made on Form C. A. 5, Claim for Compensation on Account of Death. Form C. A. 5 will be submitted to the Personnel Office in duplicate.

c. Claim for reimbursement of travel expense incident to securing treatment (see paragraphs 6 c and 6 d above) will be made on Standard Form No. 1012, Voucher for Per Diem and/or Reimbursement of Expenses Incident to Official Travel. This claim will be submitted to the Personnel Office through appropriate administrative channels.

d. The Assistant Director (Personnel) or his designee will review each claim to determine whether it is to be processed under the provisions of the Federal Employees' Compensation Act or the Central Intelligence Agency Act.

(1) Claims processed under the Federal Employees' Compensation Act will be forwarded by the Personnel Office to the Bureau of Employees' Compensation for adjudication, on a classified or unclassified basis as the situation warrants.

(2) Claims processed under the Central Intelligence Agency Act will be administratively approved or disapproved by the Assistant Director (Personnel) or his designee.

(a) Approved claims will be forwarded to the Finance Division for payment.

(b) Disapproved claims will be returned to the claimant with a memorandum stating the reasons for disapproval. A copy of this memorandum will be forwarded to the Office Chief concerned.

APPENDIX A

COMPENSATION BENEFITS

COMPENSATION BENEFITS

	TYPE	QUALIFICATIONS	AMOUNT
1.	Hospital and medical expenses	If approved facilities used and procedures followed	Varies with case
2.	Travel to place of treatment	If local facilities are not suitable or available	Varies with case
3.	Services of an attendant	If necessary because employee is so helpless as to require constant attention	Not to exceed $75 per month
4.	Compensation for time lost	If desired. May take accrued sick and annual leave	66 2/3% of monthly salary or schedule award
5.	Augmented compensation for dependents	If one or more dependents. Relationship: Wife, Husband, Unmarried child, Dependent Parent	8 1/3% of monthly pay (Limited to that part of monthly pay not in excess of $420)
6.	Funeral bills	If death results from the injury	Discretionary. Not to exceed $400
7.	Death Benefits		
	a. Widow	a. Until remarriage or death	a. 45%
	b. Widower	b. If wholly dependent upon wife. ('Til remarriage, death or capable of self-support)	b. 45%
	c. Children	c. 'Til child marries, dies, or reaches 18	c. To widow 40%, and 15% for each child not to exceed 75%
	d. Orphan children	d. Same as c	d. 35% for one child and 15% for each additional child not to exceed 75% divided among such children share and share alike
	e. Dependent Parent	e. (1) If one dependent and one not (2) If both are dependent	e. (1) 25% (2) 20% to each
	f. Other dependents	f. (1) If one dependent (2) If more than one (3) If one wholly dependent but one or more only partially dependent	f. (1) 25% (2) 30% share alike (3) 10% share alike

APPENDIX B

SAMPLE FORMS

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

Federal Employees' Compensation Act

This notice should be submitted to the immediate superior by an injured civil employee of the Federal Government, or by someone on his behalf, within 48 hours after the injury. Notice may be given either personally or by mail. It should be retained by the official superior unless the injury causes disability for work beyond the day or shift when injury occurred, or results in any charge against the Bureau for medical expense, when it should be forwarded to the U. S. DEPARTMENT OF LABOR, Bureau of Employees' Compensation, together with the official superior's report of injury, Form C. A. 2. Before compensation is paid, written claim on Form C. A. 4 must be submitted to the Bureau.

Date of this notice _____, 19____

1. I hereby certify that I am employed as a _____ (Occupation)

at the _____ (Place of employment)

and on _____ (Day of week), _____ (Date), 19____, at _____ (Hour, a. m. or p. m.) m.

I was injured in the performance of my duties at _____ (Location where injury occurred)

_____

2. Cause of injury _____ (Describe as best you can how and why injury occurred)

_____

_____

_____

3. Nature of injury _____ (Name part of body affected—fractured left leg, bruised right thumb, etc.)

_____

4. Names of witnesses to injury _____

_____

_____

5. If this notice was not given within 48 hours after the injury, explain reason for delay and state name of person to whom notice was first given, and when _____

_____

_____

This injury was not caused by my willful misconduct, intention to bring about the injury or death of myself or of another, nor by my intoxication, and I hereby make claim for compensation and medical treatment to which I may be entitled by reason of the injury sustained by me.

Name _____

Address _____ (Street and number)

_____ (City or town) _____ (State)

OFFICIAL SUPERIOR'S REPORT OF INJURY

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department _____ (*War, Navy, etc.*) 2. Bureau or office _____ (*Engineer, Navigation, etc.*)
3. Place of employment _____ (*Arsenal, navy yard, etc.*), _____ (*City*), _____ (*State*)
4. Reporting office _____ (*Location of reporting office or division headquarters*)
5. Name of superintendent or foreman in charge when injury occurred _____

The injured employee

6. Name of injured employee _____ (*Give first name in full*) 7. Age _____ 8. Sex _____ 9. Race _____
10. Home address _____ (*Street and number*), _____ (*City or town*), _____ (*State*)
11. Occupation and division _____ (*Give both, as laborer, hull division; helper, machine shop, etc.*) 12. Was employee doing his regular work? _____ If not, what work? _____
13. Total length of service with the Government as a civilian? _____
14. How long at present work in this establishment? _____
15. Dates of other injuries _____
16. Rate of pay on date of injury, $_____ per _____ { and subsistence valued at $_____ per _____ / and quarters valued at $_____ per _____
17. Employee begins work at _____ (*Hour, a. m. or p. m.*) m. 18. Regular day's work ends _____ (*Hour, a. m. or p. m.*) m.
19. Hours worked per day _____ 20. Days paid per week _____

The injury

21. Place where injury occurred _____ (*Give exact location, as name or number of building and division, etc.*)
22. Date of injury _____, 19____; day of week _____; hour of day _____ (*a. m. or p. m.*) m.
23. Date employee stopped work _____, 19____; day of week _____; hour of day _____ (*a. m. or p. m.*) m.
24. Date employee's pay stopped _____, 19____; day of week _____; hour of day _____ (*a. m. or p. m.*) m.
25. Has employee returned to work? _____ (*Give date and hour*)
26. Will employee receive pay for any portion of above absence on account of:
    (*a*) Annual leave _____ (*Give exact dates*)
    (*b*) Sick leave _____ (*Give exact dates*)
    (*c*) Any other reason _____ (*Give exact dates*)
27. Describe in full how injury occurred _____
28. State part of body injured and nature and extent of injury _____
29. Did injury cause loss of any member or part of member? _____ If so, describe exactly _____
30. Was employee injured while in performance of duty? _____ If not, or in doubt, give detailed statement _____
31. Was injury caused by:
    (*a*) Willful misconduct of the employee? _____ (*b*) Intention of employee to bring about injury or death of himself or another? _____ (*c*) Employee's intoxication? _____
    (*If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion*)
32. Was written notice of injury given within 48 hours? _____ If not, did immediate superior have actual knowledge of injury? _____
    (*Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours*)
33. Names and addresses of witnesses to injury _____
    (*If disability will continue for more than one day, have statements of witnesses made on reverse side of this form*)
34. Was injury caused by a third party other than a Government employee or agency? _____ If so, has employee been instructed in procedure under the Bureau's regulations? _____
    (*A detailed statement should be forwarded with this report*)

Medical attendance

35. Name and address of physician who first attended case _____
36. How soon after injury? _____
37. To what hospital sent? _____ Location _____
38. Name and address of physician now attending case _____

Signed this _____ day of _____, 19____ _____ (*Signature of reporting officer*)

at _____ _____ (*Title*)

C. A. 2
Revised May 24, 1944 (over)

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

Signed this _____ day of _____, 19____

_____
(*Signature of witness*)

Signed this _____ day of _____, 19____

_____
(*Signature of witness*)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ (*Name of employee*) was given first-aid treatment, or examined, on _____, 19____, at _____ m., and _____ (*Was or was not*) disabled for work. Probable length of disability will be _____ In my opinion disability _____ (*Was or was not*) due to injury on _____, 19____

Nature of injury as found on examination _____

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19____

at _____

_____
(*Signature of medical officer*)

_____
(*Title*)

U. S. GOVERNMENT PRINTING OFFICE 16—6027

CLAIM FOR COMPENSATION ON ACCOUNT OF INJURY

[To be filed with the official superior, within 60 days after the injury causing disability for more than 3 days, for transmission to the U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION]

CLAIM MUST BE FILED WITHIN ONE YEAR AFTER INJURY

NOTICE: **Section 39 of the Compensation Act of September 7, 1916, provides that whoever makes, in any claim for compensation, any statement, knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $2,000, or by imprisonment for not more than one year, or by both such fine and imprisonment.**

1. Name of injured employee _____ [Give first name in full] 2. Age _____ 3. Sex _____
4. Mail address _____ [Street and number] [City or town] [State]
5. Married, single, widowed. 6. Race _____ 7. Occupation and division _____
8. Rate of pay when injured, $_____ per _____ [Cross out two words]
   (a) Were subsistence and quarters furnished by the United States? _____
   (b) If so { were they received in addition to rate of pay? _____ / or / was their value deducted from pay? _____ } [Answer "Yes" to one]
   (c) In either case, state value: Subsistence, $_____ per _____; quarters, $_____ per _____
9. Time of injury _____, 19____ _____ _____ m.
   [Date] [Day of week] [Hour a. m. or p. m.]
10. Disability for work began _____, 19____ _____ _____ m.
    [Date] [Day of week] [Hour a. m. or p. m.]
11. First able to resume usual occupation _____, 19____ _____ _____ m.
    [Date] [Day of week] [Hour a. m. or p. m.]
12. Period for which compensation is claimed. From _____ to _____
13. Have you received any pay from the Government during period of disability:
    On account of annual or sick leave _____ Dates _____, Total amount, $_____
    Specify any other reason _____ Dates _____, Total amount, $_____
14. Have you worked for anyone during the period of disability? _____ If so, give name and address of employer, dates worked, rate of pay, and total amount earned _____
15. Were you furnished subsistence or quarters (other than in hospital) during period of disability? _____
    If so, give dates on which subsistence or quarters, or both, were furnished _____
16. If medical, surgical, or hospital service was furnished by private physicians or hospitals, state amount of expense incurred, $_____ and submit an itemized bill for this service with an explanation of reason for not using United States medical officers or hospitals, if available.
17. If transportation and other expenses necessary to enable you to secure proper medical and hospital treatment were incurred by you, state amount of expense so incurred, $_____ If reimbursement is claimed submit itemized receipted bill for such expenses.
    [Give dates, places of travel, and amount paid; also any special expense necessary because you had to travel from your regular place of residence in order to get proper medical treatment]
18. Place where injury occurred _____ [Give exact location, as name or number of building, and division, etc.]
19. Cause of injury _____ [State exactly how injury occurred]
20. Nature and extent of injury causing disability _____
21. Have you made claim against any person for damages on account of the injury described above? _____
    If you have received any money in payment of damages, state amount, $_____
22. (a) Have you ever been in the military or naval service? _____ If so, state approximate periods served and in what organization _____
    (b) Have you ever applied for compensation or pension on account of such service? _____ If so, give claim number and office where filed _____
    (c) Are you now receiving compensation or pension, retainer, or retirement pay on account of such service? _____ If so, give details _____
23. Have you applied for, or received, annuity under Civil Service Retirement Act? _____
24. Dates of other injuries, if any, on account of which you have made claims for compensation _____

I HEREBY make claim for compensation on account of the injury described above, which was sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled on account of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement set forth above in support of my claim is true to the best of my knowledge and belief.

Signed this _____ day of _____, 19____, at _____

_____ [Signature of claimant]

_____ } ss:
_____ }

Subscribed and sworn to before me this _____ day of _____, 19____

_____ [Signature of official administering oath]

_____ [Title] [In and for]

C. A. 1
Revised May 24, 1950

16—11485-2

ATTENDING PHYSICIAN'S CERTIFICATE AND MEDICAL REPORT OF DISABILITY

I CERTIFY that _____ [*Name of injured employee*] has been under my professional care from _____ to _____, inclusive, for the effects of injuries sustained on _____

In my opinion, employee has been *totally disabled* for all work from _____ to _____ and *partially disabled* for usual occupation from _____ to _____

Patient { was / may be } able to resume regular work _____

Patient { was / may be } able to resume light work _____

1. Dates of treatment visits: (*a*) Office _____
   (*b*) Home _____ (*c*) Hospital _____
2. Nature of treatment provided for effects of injury _____
   (*a*) Operation _____ (*b*) Date performed _____
3. What further treatment is recommended? _____
   Specify special services indicated, if any, such as: Consultation, hospitalization, orthopedic appliances, etc. _____
4. State what history of injury was given by employee _____
5. Describe the symptoms or physical findings for which treatment was given _____
   (*a*) X-ray—laboratory—specialist's reports _____
6. State how your findings confirm your opinion that the disability was due to injury _____
7. Describe complicating and other concurrent diseases or disabilities present _____
8. Employee was confined (*a*) to his *home* from _____ to _____; (*b*) to *bed* from _____ to _____
9. Are permanent effects of the injury probable? _____ Describe in detail _____
10. If injury caused loss or dysfunction of a part, describe such loss in terms of function _____

NOTE.—In all cases where (*a*) the disability is protracted 30 days or more, or (*b*) where the medical relationship of the condition to an alleged injury or to occupational conditions is not clear, forward a detailed medical report describing the onset and clinical course of the condition, and discuss the medical aspects of the case which justify your opinion of the causal relationship to an injury.

I am licensed to practice medicine and surgery in the State of _____

_____
[*Signature of attending physician*]

Signed this _____ day of _____, 19____

_____ [*Street and number*] _____ [*City and State*]

CERTIFICATE OF OFFICIAL SUPERIOR OF INJURED EMPLOYEE

[Report of injury (Form C. A. 2) if not heretofore forwarded to the Bureau, should accompany this claim.]

If any circumstances have arisen which alter the conclusions stated in the official report of injury (Form C. A. 2), or if the official superior disagrees with any of the statements made in the claim for compensation, it is requested that a full explanatory statement be made under "Remarks."

1. If the injured employee is a piece worker or an irregular worker, what were his gross earnings during the month immediately preceding the injury? $_____; actual dates on which he worked _____
   [*For example, if the employee was injured on the 7th of February, his gross earnings should be given for January 7 to February 6, inclusive*]
2. Has employee resumed work? _____ If so, give date and hour _____
3. Has employee been paid for any portion of the absence for which compensation is claimed? _____ If so, state inclusive dates _____
4. Remarks _____

I HEREBY CERTIFY that the person who executed the foregoing claim for compensation was injured while in the performance of his duty for the United States. An official report of this injury on Form C. A. 2 has been made, and all statements made in said report are true to the best of my knowledge and belief.

_____
[*Signature of official superior*]

Signed this _____ day of _____, 19____

_____
[*Title*]

at _____

U. S. GOVERNMENT PRINTING OFFICE 16—11485-1

APPENDIX C

LIST OF FORMS

FORMS USED IN REPORTING INJURIES, PROCESSING CLAIMS, AND FILING APPEALS

Listed below are the forms required in injury and death cases under the United States Employees' Compensation Act of 1916, as amended. This list identifies the title of each form and indicates by whom and when each form should be submitted. Non-asterisked forms are obtained from the Personnel Office. Forms indicated by one asterisk are furnished direct to claimants by the Bureau; those indicated by two asterisks are furnished only to hospitals and physicians.

Form	Title	To be submitted-- By--	When--
C. A. 1	Employee's Notice of Injury or Occupational Disease.	Employee (or someone acting in his behalf).	Within 48 hours or as soon after injury as is practicable. Form filed in employee's personnel folder in office injury cases not reported to the Bureau.
C. A. 2	Official Superior's Report of Injury	Employee's supervisor	Same as Form C. A. 1, if injury results in disability for work beyond the day or shift of occurrence, or might result in any medical charge against the compensation fund.
C. A. 2	Official Superior's Report of Injury. (To cover recurrence of disability from original injury.)	Employee's supervisor	Immediately when an injured employee is again disabled from the same injury. Forms should be marked "Recurrence," and should contain sufficient facts to identify the injury. New dates when work and pay stopped and part of the new absence covered by leave should also be shown. If disability has ended when the report is made, the date and hour of return to duty should be shown; otherwise a new report on Form C. A. 3 should be made when the employee returns to work or disability ceases.

Form	Title	To be submitted-- By--	When--
C. A. 3	Report of Termination of Total or Partial Disability. (Upper Portion)	Employee's Supervisor....	Immediately upon employee's return to work after disability, unless such report has been made on Form C. A. 7, or otherwise.
C. A. 3	Report of Death (Lower Portion)	Designated official.....	Immediately, and to be accompanied by report on Form C. A. 2, if such form has not previously been submitted.
C. A. 4	Claim for Compensation on Account of Injury	Employee (or someone acting in his behalf).	Within 10 days after pay stops, but not later than 60 days after injury. Explanation must accompany claim if submitted later than 60 days after injury.
C. A. 4A	Application for Augmented Compensation for Disability	Employee (or someone acting in his behalf).	Accompanies C. A. 4 when dependency benefits are claimed.
C. A. 4B	Application for Award for Disfigurement.	Employee (or someone acting in his behalf).	Accompanies C. A. 4 in cases of disfigurement of face, head, or neck.
C. A. 5	Claim for Compensation on Account of Death.	Beneficiary	As soon as possible after death, but not later than 1 year.
C. A. 5A	Application for Balance of Schedule Due When Death is From Causes Other than the Injury.	Beneficiary	Within 1 month after death and not later than 1 year.
C. A. 8	Claim for Continuance of Compensation on Account of disability.	Employee (or someone acting in his behalf).	At least once a month.
C. A. 10	Placard for Posting		
C. A. 11	Pamphlet Containing Resume of Employee's Rights to Compensation Benefits.		

Form	Title	To be submitted-- By--	When--
C. A. 12	Claim of Widow or Widower for Continued Compensation on Account of Death.	Widow or widower or guardian on behalf of such beneficiary if mentally incompetent	On the 1st day of January and July of each year while the compensation continues.
C. A. 13	Claim of Guardian of Minor Children for Continued Compensation on Account of Death.	Legal nor natural guardian or guardian ex officio on behalf of a minor or mentally incapacitated beneficiary other than widows, widowers, parents, or grandparents.	Same as Form C. A. 12.
C. A. 13A	Claim for Continued Compensation on Account of Death by Dependent Physically Incapable of Self-Support.	Incapacitated beneficiaries other than widows, widowers, parents, or grandparents who are not minors and have no guardian.	Same as Form C. A. 12.
C. A. 14	Request of Dependent Parents or Grandparents for Additional Compensation on Account of Death.	Dependent parents or grandparents.	Same as Form C. A. 12.
C. A. 16	Request for Treatment of Injury Under the United States Employees' Compensation Act. (Request for treatment by non-designated physician will be issued in letter form.)	Employee's supervisor or Medical Officer.	Immediately after the accident, if practicable. Authorization for emergency treatment may be given before issuance of this form, provided it is issued within 48 hours thereafter.
C. A. 17	Request for Treatment of Injury Under the United States Employees' Compensation Act When Cause of Injury is in Doubt. (Same as Form C. A. 16.)	Employee's supervisor or Medical Officer.	Immediately in order that it can be forwarded to proper office for necessary action.
C. A. 20	Attending Physician's Report.	Attending physician	As soon as possible.
C. A. 21	Discharge Report of Injury Case.	Hospital, dispensary, or designated physician.	When patient is discharged.

Form	Title	To be submitted-- By--	When--
C. A. 32	Report of Hernia	Claimant and attending physician	As soon as possible.
C. A. 33	Request (by Bureau) for Medical Examination.	Bureau	As deemed necessary
C. A. 42	Affidavit Relating to Representatives of Deceased Beneficiaries.	Any person having knowledge of the funeral and burial expenses other than the undertaker or a member of his establishment. (This form is used when there is no administration of the deceased employee's estate in claiming burial allowance or compensation due the deceased employee at the time of his death.)	As soon as possible after burial of deceased employee.
C. A. 43	Affidavit of Undertaker	Undertaking establishment.	As soon as possible after burial of deceased employee.
C. A. 69	Employee's Claim for Continuance of Compensation on Account of Disability When Case Is Carried on Automatic Roll.	Employee	In lieu of C. A. 8
C. A. 76	List of Physicians and Hospitals Approved by Bureau Which Are Available to Injured Employees.		
C. A. 83	Employee's Notice of Compensation Payment by Bureau.	Bureau	
C. A. 86	Official Superior's Notice of Compensation Payment by Bureau.	Bureau	
C. A. 95	Employee's Claim for Continuance of Compensation.	Employee	In lieu of C. A. 8 when medical evidence is not required

Form	Title	To be submitted-- By--	When--
C. A. 96	Employee's Affidavit Disclosing Earnings, if any, During Disability.	Employee (partially disabled)	As requested by Bureau.
*C-1	Agreement of Claimant	Claimant (or attorney authorized to act in his behalf).	Upon approval of Claimant's attorney by the Bureau.
*S-69	Public Voucher for Services and Supplies of Hospitals and Physicians.	Injured employee, physicians, nurses, hospitals, and any person or firm furnishing supplies or services for medical and allied expenses. If signature of employee cannot be obtained, a concise explanation of the reason must be included.	When employee is discharged from treatment, unless treatment extends for more than 30 days, in which event it shall be submitted at the end of each 30-day period.
Standard Form 1012.	Voucher for Per Diem and/or Reimbursement of Expenses Incident to Official Travel.	Injured employee	When travel is completed, or if repeated trips are made, as often as convenient in accordance with Standard United States Government Travel Regulations.
*Standard Form 1034.	Public Voucher for Purchases and Services Other Than Personal.	Undertaking establishment or person or firm furnishing services in connection with funeral or burial expenses of deceased employee.	As soon as possible after burial of deceased employee.
AB-1	Application for Review	Person affected by Bureau's decision.	Within 90 days after issuance of final decision by Bureau. Time limit may be waived by Board in extenuating cases, provided application is filed within 1 year.