



Florida Trail Association VOLUNTEER INJURY INSTRUCTIONS



This packet contains information about dealing with injuries of FTA volunteers. It should be carried by each volunteer leader. Volunteer leaders should be familiar with the contents of this packet and ensure that Trailhead Communication and Emergency Action Plans are in place before an accident resulting in injury occurs.

IF AN INJURY OCCURS, FOLLOW THESE STEPS:

1. The First Aid Lead initiates care for the patient(s). Get patient's medical and emergency contact information from Crew Leader. Write medical or SOAP notes.
2. Communications Lead uses Trailhead Communications Plan (TCP) and calls 911 or Dispatcher if needed. Relay pertinent medical or SOAP notes written by the First Aid Lead.
3. Get emergency treatment by a medical provider, if needed.
4. Evacuate, send medical and emergency contact information and medical or SOAP note with patient.
5. Report injury to agency authorities and FTA. In non-emergency situations, this notification occurs before formal medical care is sought. See Volunteer Injury Instructions for FTA Contacts. Agency contacts are listed on TCP.
6. Contact the individual named on the injured person's sign-up sheet.
7. Documentation. At a minimum, a form CA-1 (Report of Injury) should be completed by the injured party for all injuries (even if medical treatment is not sought); and witness statements should be included. **All injuries should be reported within 24 hours of occurrence.**

THIS PACKET INCLUDES:

1. Florida Trail Association Volunteer Injury Instructions
2. FTA Trailhead Communications Plan (1 sample copy, to be completed for each project)
3. FTA Emergency Action Plan (1 sample copy, to be completed for each project)
4. Form SOAP Note (blank – 2 copies)
5. Form CA-1 Report of Injury (blank – 2 copies)
6. Form FTA Witness Statement (blank – 2 copies)

Notify the FTA Trail Operations Director for the area where the injury occurred. If he/she is unavailable, please call the FTA Volunteer Program Coordinator.

Name	Title	Phone Number
Alex Stigliano	Trail Operations Director	828-333-1529
Van Tran	Community Outreach Coordinator	352-538-7639
Shawn Thomas	FNST USDA FS Trail Administrator	850-523-8586



Florida Trail Association Trailhead Communications Plan (TCP)



Crew Leader: Fill this out *BEFORE* arriving at trailhead. Bring two copies. At trailhead, give one copy to Communications Lead and put the other in the First Aid Kit (keep with a pen in a sealed waterproof bag.)

Agency Contact Information

Business Hours Contact: _____	Phone Number: _____
After Hours Contact: _____	Phone Number: _____
Dispatch: _____	Phone Number: _____
FTA Contact: _____	Phone Number: _____

Project Information

Trailhead and County: _____	Best Location for Reception Near Worksite:	_____
Date/Time Going In: _____		
Date/Time Coming Out: _____	Crew Leader Cell #:	_____
Crew Leader Name: _____		
Gate Code/Combination: _____		

Location Information

Name of Trailhead: _____	Road and Milepost: _____
Nearest Intersection: _____	County and State: _____
GPS Coordinates: WGS 84 _____	Nearest Town/City: _____
Helicopter Landing Spot: _____	Township and Range: _____

Transport Injured to:

Nearest Hospital: _____	Distance from Trailhead: _____
Hospital Phone Number: _____	Hospital Address: _____

Driving directions from trailhead:

Cell Phone Instructions

911 calls from cell phones can land in a far-away regional center. The call-taker needs the following information immediately:

- Your wireless phone number in case disconnected
- The location you're calling from. See below.
- What type of emergency you have (medical, require ambulance; injury specifics)

In addition to 911, if you might need a helicopter. List local medical helicopter phone number(s) here:

Other Pertinent Information



Florida Trail Association Emergency Action Plan (EAP)

(Complete with volunteers at each Tailgate Safety Session)

Crew Leader: *Delegate the following roles at the trailhead. This limits confusion that can accompany a serious accident. Show everyone where the EAP is kept, in case you become incapacitated.*

Title	Volunteer Assigned	Duties
Situation Manager		Usually the Crew Leader
Alternate Situation Manager		
First Aid Lead		Most medically experienced in crew; carries first aid kit and takes notes
Communications Lead		Carries radio/cell phone, ensures it is charged, tuned, and ready; carries Trailhead Communication Plan, calls for assistance

IN THE EVENT OF AN EMERGENCY, FOLLOW THESE STEPS:

1. The First Aid Lead initiates care for the patient(s). Get patient's medical and emergency contact information from Crew Leader. Write medical or SOAP notes.
2. Communications Lead uses Trailhead Communications Plan (TCP) and calls 911 or Dispatcher if needed. Relay pertinent medical or SOAP notes written by the First Aid Lead.
3. Evacuate, send medical and emergency contact information and medical or SOAP note with patient.
4. Get emergency treatment by a medical provider, if needed. (Inform agency authorities and FTA first, if possible. See Volunteer Injury Instructions: Treatment Procedures for details.)
5. Report injury to agency authorities and FTA. In non-emergency situations, this notification occurs before formal medical care is sought. See Volunteer Injury Instructions for FTA Contacts. Agency contacts are listed on TCP.
6. Contact the individual named on the injured person's sign-up sheet.
7. Documentation. At a minimum, a form CA-1 (Report of Injury) should be completed by the injured party for all injuries (even if medical treatment is not sought); and witness statements should be included. All injuries should be reported within 24 hours of occurrence.

Patient Assessment	
Patient Name:	Date: Time:
A irway	
B reathing	
C irculation	
D isability	
E nvironment	
F ocused Exam	
Head/Neck	
Shoulders/Clavicle	
Chest/Sternum	
Abdomen	
Pelvis/Hips	
Legs/Feet	
Arms/Hands	
Back Cervical Thoracic Lumbar Sacrum Coccyx	
G et Vitals	
Time	
Level of Responsiveness (AVPU)	
Heart Rate/Rhythm/Quality	
Respiration Rate/Rhythm/Quality	
Skin Color/Temp/Moisture	
H istory	
Chief Complaint	
MOI (Mechanism of Injury)	
S ymptoms	
O nset	
P rovoke/Palliate	
Q uality	
R adiate (Leads to where?)	
S everity (1-10)	
T rend (When did it start)	
A llergies	
M edications	
P ertinent History	
L ast Intake/Output	
E vents Preceding	

Cut Here

Cut Here

SOAP Note					
	Date:	Time:			
Patient	Name:				Age:
	Address:				M or F
	Phone:			Notify:	
	Relation:			Phone:	
Subjective	(moi c/c opqrst)				
	(Patient Exam SAMPLE History)				
Objective					
Vital Signs	Time	AVPU	HR/Character	RR/Character	SCTM
Assessment					
Plan					

Patient Assessment	
Patient Name:	Date: Time:
A irway	
B reathing	
C irculation	
D isability	
E nvironment	
F ocused Exam	
Head/Neck	
Shoulders/Clavicle	
Chest/Sternum	
Abdomen	
Pelvis/Hips	
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L ast Intake/Output	
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SOAP Note					
Date:		Time:			
Patient	Name:				Age:
	Address:				M or F
	Phone:			Notify:	
	Relation:			Phone:	
Subjective	(moi c/c opqrst)				
	(Patient Exam SAMPLE History)				
Vital Signs	Time	AVPU	HR/Character	RR/Character	SCTM
Assessment					
Plan					

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step		
7. Employee's 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	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
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13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation code	
	b. Type code	c. Source code
	OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- b. Sick and/or Annual Leave

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.

Signature of employee or person acting on his/her behalf _____ **Date** _____

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 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.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed
Address	City	State ZIP Code

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report	
17. Agency name and address of reporting office (include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
ZIP Code	

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
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22. Date of Injury Mo. Day Yr.	23. Date notice received Mo. Day Yr.	24. Date stopped work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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25. Date pay stopped Mo. Day Yr.	26. Date 45 day period began Mo. Day Yr.	27. Date returned to work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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28. Was employee injured in performance of duty? Yes No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)	31. Name and address of third party (Include city, state, and ZIP code)
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32. Name and address of physician first providing medical care (Include city, state, ZIP code)	33. First date medical care received Mo. Day Yr.
	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.	37. Pay rate when employee stopped work \$ Per
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Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D) No lost time, medical expense incurred or expected: forward this form to OWCP Lost time covered by leave, LWOP, or COP: forward this form to OWCP First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason in detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

- a) The disability was not caused by a traumatic injury.
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is not a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 45 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continues the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.
- (2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.
- (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.
- (4) Vocational rehabilitation and related services where directed by OWCP.
- (5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle)				2. Social Security Number	
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step		
7. Employee's 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	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

10. Date injury occurred Mo. Day Yr.	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.	12. Employee's occupation
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13. Cause of injury (Describe what happened and why)

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)	a. Occupation code	
	b. Type code	c. Source code
	OWCP Use - NOI Code	

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- b. Sick and/or Annual Leave

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.

Signature of employee or person acting on his/her behalf _____ **Date** _____

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 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.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness	Signature of witness	Date signed
Address	City	State ZIP Code

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report	
17. Agency name and address of reporting office (include city, state, and zip code)	OWCP Agency Code
	OSHA Site Code
ZIP Code	

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	21. Regular work schedule <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.
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22. Date of Injury Mo. Day Yr.	23. Date notice received Mo. Day Yr.	24. Date stopped work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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25. Date pay stopped Mo. Day Yr.	26. Date 45 day period began Mo. Day Yr.	27. Date returned to work Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
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28. Was employee injured in performance of duty? Yes No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? Yes (If "Yes," explain) No

30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)	31. Name and address of third party (Include city, state, and ZIP code)
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32. Name and address of physician first providing medical care (Include city, state, ZIP code)	33. First date medical care received Mo. Day Yr.
	34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? Yes No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.	37. Pay rate when employee stopped work \$ Per
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Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D) No lost time, medical expense incurred or expected: forward this form to OWCP Lost time covered by leave, LWOP, or COP: forward this form to OWCP First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason in detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

- a) The disability was not caused by a traumatic injury.
- b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;
- c) The employee is not a citizen or a resident of the United States or Canada;
- d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;
- e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;
- f) The injury was not reported on Form CA-1 within 30 days following the injury;
- g) Work stoppage first occurred 45 days or more following the injury;
- h) The employee initially reported the injury after his or her employment was terminated; or
- i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines."

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

- (1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continues the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.
- (2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.
- (3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.
- (4) Vocational rehabilitation and related services where directed by OWCP.
- (5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

Which occurred on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior

Title

Date (Mo., Day, Yr.)



Florida Trail Association Witness Statement

(Attach additional sheets if necessary)



1. Did you see the accident?

2. When did the accident happen?

A. Time

B. Date

3. Where did the accident happen?

4. Tell, in your own way, how the accident happened.

5. Where were you when the accident occurred?

6. Was anyone injured, and if so, extent of injury known?

7. Describe the apparent damage to private property.

8. Describe the apparent damage to government property.

9. Please draw a diagram below of what happened at the worksite:

10. Name of witness completing this form

A. Signature of witness

B. Today's day

C. Witness' telephone number

D. Home address of witness (include city, state, zip code)



Florida Trail Association Witness Statement

(Attach additional sheets if necessary)



1. Did you see the accident?

2. When did the accident happen?

A. Time

B. Date

3. Where did the accident happen?

4. Tell, in your own way, how the accident happened.

5. Where were you when the accident occurred?

6. Was anyone injured, and if so, extent of injury known?

7. Describe the apparent damage to private property.

8. Describe the apparent damage to government property.

9. Please draw a diagram below of what happened at the worksite:

10. Name of witness completing this form

A. Signature of witness

B. Today's day

C. Witness' telephone number

D. Home address of witness (include city, state, zip code)

FTA SAW RELATED INCIDENT REPORT

(Submit to FTA within 6 days of incident)

Saw operator contact information (name, title, address, email, and phone number): _____ _____ _____	
Incident location: _____ _____ _____	
Date and time of incident/injury:	
Name of person(s) involved:	Volunteer <input type="checkbox"/> Seasonal Employee <input type="checkbox"/> Permanent Employee <input type="checkbox"/> Timber <input type="checkbox"/> Fire <input type="checkbox"/> Recreation <input type="checkbox"/> Engineering <input type="checkbox"/> LEI <input type="checkbox"/>
Person Reporting Incident:	
Incident/activity narrative (examples: line construction, trail clearing, brush crew): _____ _____ _____	
Type/model of chainsaw or crosscut saw (examples: Stihl 461, 28" bar, chisel bit or 4' Crosscut, lance tooth): _____	
PPE used: hard hat <input type="checkbox"/> eye protection <input type="checkbox"/> ear protection <input type="checkbox"/> long-sleeved shirt <input type="checkbox"/> gloves <input type="checkbox"/> long pants <input type="checkbox"/> chaps <input type="checkbox"/> 8" leather boots <input type="checkbox"/> Other: _____	
Saw operator experience & certification level (example: A Sawyer bucking/felling 1 month, C Sawyer Bucking Only, 5 yrs.): _____	
Saw recertification date: chainsaw: _____	crosscut saw: _____
Unit Saw Program Coordinator (name, title, email, phone number & address): _____ _____	
National Recognized Sawyer Training Curriculum attended: S-212 <input type="checkbox"/> MTDC <input type="checkbox"/> Game of Logging <input type="checkbox"/> other: _____	
Certifying Official who signed saw card (name, title, email, address & phone number): _____ _____	
Extent of accident and/or injury): _____ _____ _____	

SAW RELATED INCIDENT REPORT

(Submit to FTA within 6 days of incident)

Description of incident (what happened?):	
Assessment of cause:	
Submitted by:	
Witness statement completed by:	Date:
Name, email, phone number of witness(es):	

Line officer review and or comments:	
Line officer signature:	Date:
Note: This incident report does not eliminate or change the immediate Accident Notification and investigation Procedures outlined in FSH 6709.12, Chapter 10.	