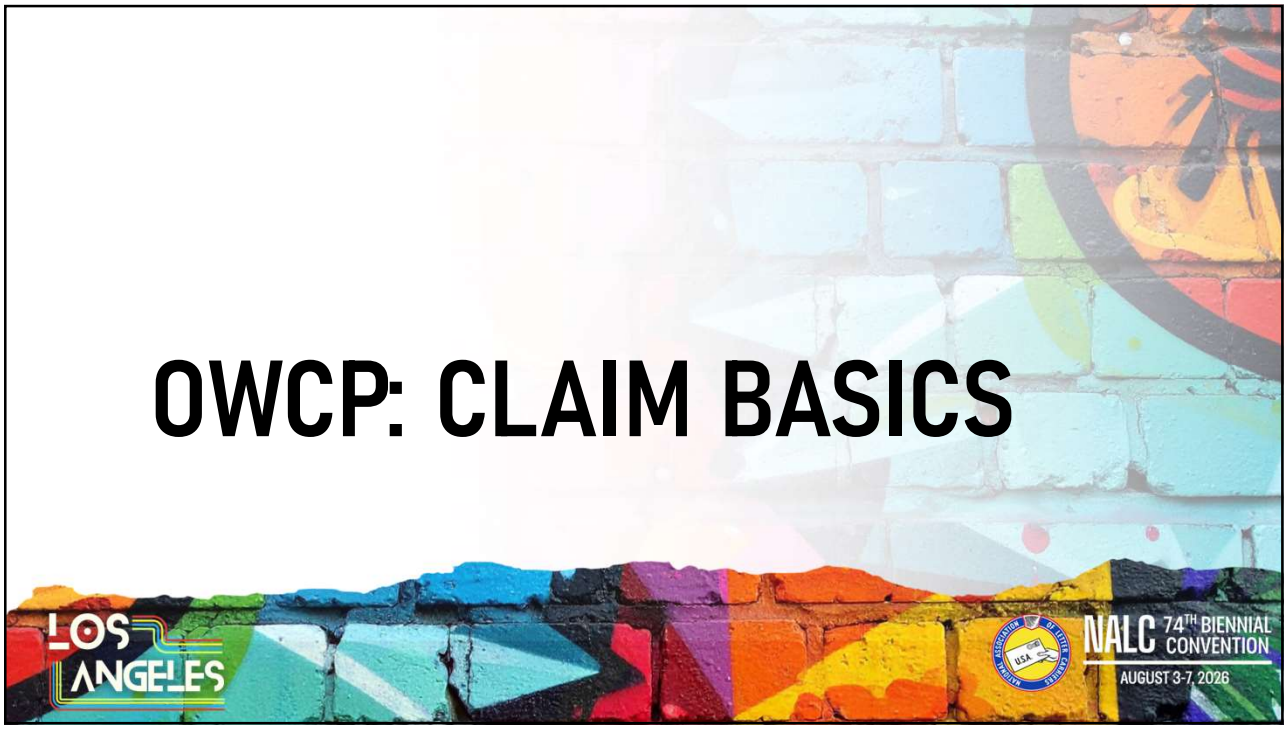

1

CODE OF CONDUCT

NALC is committed to providing an environment free from discrimination and harassment, regardless of an individual's race, ethnicity, religion, color, sex, age, national origin, sexual orientation, disability, gender identity or expression, ancestry, pregnancy, or any other characteristic prohibited by law. We ask you to embrace our values of equity and equality, and conduct yourself accordingly.

This meeting has a designated individual as the first point of contact for anyone who feels they have experienced discriminatory, harassing or otherwise unacceptable behavior. We urge you to contact them if you have any concerns.

Designee: Sheri Melvin, available in the Headquarters Office

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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ACT I – CA-1

Traumatic Injury the **wrong** way

3

Traumatic Injury

Traumatic Injury (TI) – *means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.*(20 CFR 10.5 (ee))

4

Traumatic Injury – Forms

- CA-1 – Traumatic Injury
- CA-16 – Medical Authorization
- CA-17 – Duty Status Report
- CA-20 – Attending Physician's Report
- CA-7 – Claim for Compensation
- PS FORM 3971

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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<u>Filing claims electronically via ECOMP takes management out of the mix</u> at this early stage and allows the carrier to submit all pertinent information directly into the claim file immediately.

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

6

7

Traumatic Injury – DOI

- Time lost on the date-of-injury (DOI) does not count towards continuation of pay(COP)
- **Administrative leave is granted** for the remainder of the **scheduled time on the DOI**
- On the DOI, an injured employee is kept in a work status or granted "*administrative leave for any fraction of a day or shift lost, so that the employee receives pay for the entire shift that he or she is scheduled to work*," **including overtime**. (EL-505 - Section 13-4; Also, see ELM 519.54 and USPS Handbook F-21, Section 392.51)

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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Form CA-16 – *Authorization for Examination and/or Treatment*

20 CFR §10.300 :

(a) When an employee sustains a work-related traumatic injury that requires medical examination, medical treatment, or both, the employer shall authorize such examination and/or treatment by issuing a Form CA-16.

Rules of a CA-16

- ✓ CA-16 provides medical coverage for up to 60 days
- ✓ OWCP pays the bills even if claim is later denied
- ✓ Request a signed CA-16 from management
- ✓ Nothing in 20 CFR § 10 or relevant Postal manuals requires an employee to request a CA-16 from the supervisor

Timeline – CA-16

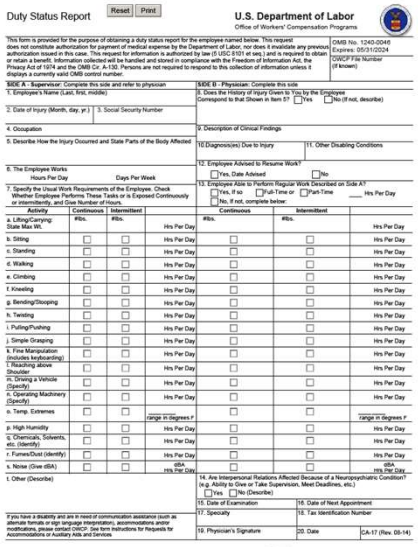
Form – 4 Hours
(20 CFR 10.300 (a))

Verbal – 48 Hours
(20 CFR 10.300 (b))

If the injury is reported more than 7 days after the date of injury, the USPS is not required to provide the form.
(See 20 CFR 10.300 (c))

11

Form CA-17 – *Duty Status Report*


Duty Status Report

Reset Print

U.S. Department of Labor
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.) and is required to obtain or retain a benefit. 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-130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1240-0046
Expires: 05/31/2024
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 Number
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)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services

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(es) 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:

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

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

CA-17 (Rev. 08-14)

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Duty Status Report CA-17

- Left side – Supervisor → Identifies work requirements
- Right side – Physician → Explains employee's restrictions
- **ALWAYS VERIFY ACCURACY** → *Example – 35 lbs. Continuously / 70 lbs. Intermittently*

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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Right to Choose a Physician

The regulations do permit the Postal Service to require an injured employee to be examined by a contract physician**, but only so long as the examination does not interfere with or delay the employee's appointment with his or her chosen physician.**

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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Whistleblower Complaint

- Section 11(c) of the OSH Act prohibits an employer from discriminating against an employee because the employee reports an injury or illness. ***29 CFR 1904.36***
- Injured workers have **30 days** to file an OSHA Whistleblower Complaint.
- https://www.whistleblowers.gov/

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Medical Evidence

- The medical evidence needed to establish a traumatic injury claim is generally much simpler and more straightforward than an occupational disease claim.
- Traumatic injuries will require a medical report signed by a physician that in all cases includes a diagnosis and, in most cases, includes a causal explanation.
- The diagnosis must be based on objective clinical findings.
- It should be noted that OWCP views pain as a symptom and will not accept it as a diagnosis.

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ACT II – CA-1

Traumatic Injury the **right** way

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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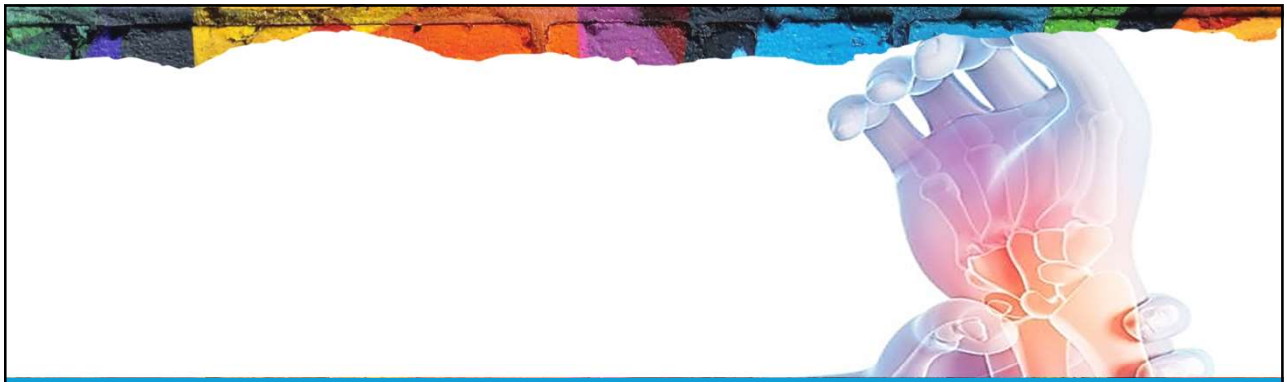

ACT III – CA-2

Occupational Disease the **wrong** way

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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Occupational Disease

Occupational Disease (OD) – *a condition which is produced by continued or repeated exposure to elements of the work environment such as noxious substances or damaging noise levels over a period longer than one workday or shift.* (20 CFR 10.5(q))

Occupational Disease – Forms

- CA-2 – Occupational Disease
- CA-17 – Duty Status Report
- CA-7 – Claim for Compensation
- PS FORM 3971
- Work Narrative

Filing claims electronically via ECOMP takes management out of the mix at this early stage and allows the carrier to submit all pertinent information directly into the claim file immediately.

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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CA-2 SUBMITTED → 10 BUSINESS DAYS → RECEIVED BY DOL

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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Occupational Disease

- **COP is not payable for an Occupational Disease**
- Compensation paid by OWCP after case approved and submission of Form CA-7.

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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Writing the Work Narrative

Easy to read

Describe a typical 8-hour day

Short paragraphs in a large font

Skip – vehicle inspections, signing for accountables, estimating overtime

The Postal Service will receive a copy of the completed work narrative and OWCP will ask if it is accurate.

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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Medical Evidence

- Clear diagnoses based on objective clinical findings
- A review of the medical history of the affected body part
- Familiarity with the work activities that have contributed to the diagnosed conditions in the affected body part
- The ***reasonable medical certainty*** standard

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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Pre-Existing Conditions

- Pre-existing injuries do not prevent you from receiving compensation for injuries to the same body part, or even the worsening of your pre-existing condition.
- If work exposes you to conditions that accelerate, aggravate, or exacerbate a pre-existing condition, it becomes compensable.
- If your job duties or incident contribute to your injury in the slightest, the injury is still fully compensable.

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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ACT IV – CA-2

Occupational Disease the **right** way

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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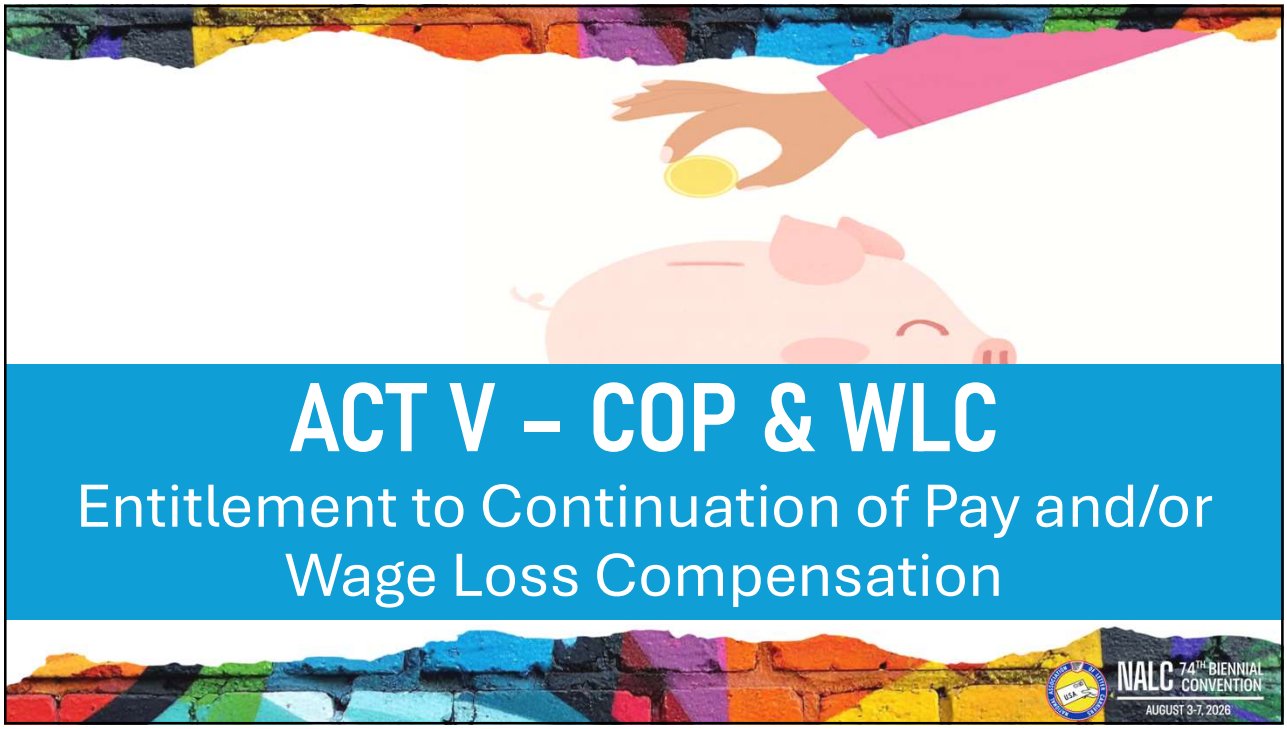


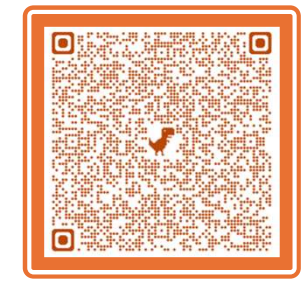
ACT V – COP & WLC

Entitlement to Continuation of Pay and/or Wage Loss Compensation

29

Traumatic Injury - COP

- **Continuation of Pay (COP)** – paid by USPS when the employee submits the CA-1 within 30-days of the DOI
- "***The intent of the COP provision is to eliminate interruption in the employee's income for the period immediately following a job-related traumatic injury****...See 5 U.S.C. 8118.*" FECA PM, Chapter 2-0807, *Continuation of Pay and Initial Claims for Compensation* (emphasis added)



30

Traumatic Injury – COP

"**Waiting Period** – FECA PM, Chapter 2-0807.12.g.: "*Postal Service employees have a three-day waiting period before COP will be granted. They may use annual leave, sick leave, or leave without pay during that period,* ***except that if the disability exceeds 14 days or is followed by permanent disability, the Postal Service employee may have that leave restored.*** *See 20. C.F.R. §10.200(c).*"
(emphasis added)

31

COP Calculations for CCAs and PTFs

Total pay earned 1 year prior (excluding OT) ÷ weeks worked = WEEKLY COP

- CCAs receive compensation based on FECA Bulletin 13-03
- PTFs receive compensation based on 20 CFR § 10.216(b)

32

Traumatic Injury – COP

- **ELM 545.733:** *In all situations, except as described in 545.732 above,* ***the employer may controvert entitlement to COP, but must continue the employees regular pay pending a final determination by OWCP.*** *OWCP has the exclusive authority to determine questions of entitlement and all other issues relating to COP.*
  (emphasis added)
- USPS **must** advise the employee of controversion

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PS Form 3971 – COP

UNITED STATES POSTAL SERVICE®

Request for or Notification of Absence

Employee's Name (Print last, first, MI.)	Employee ID	Date Submitted (MM/DD/YYYY)	No. of Hours Requested
Duck, Donald P	012 55 346	1/08/2022	80

Installation (For postmaster's leave, show city, state, and ZIP Code)	N/S Day	Pay Loc. No.	D/A Code	From: Date	Hour
Disneyland Post Office		201		12/25/2021	8:00 AM

Time of Call or Request	Scheduled Reporting Time	If Needed, Employee Can Be Reached At:	Thru: Date	Hour
	8:00 AM	☐ Do not call	1/07/2022	4:30 PM

Type of Absence
- ☐ Annual
- ☐ Holiday/AL Lv Exch
- ☐ Carrier 701 Route
- ☐ LWOP (See reverse)
- ☐ Sick (See reverse)
- ☐ Late
- ☒ COP (See reverse)
- ☐ Other _____

Documentation (For official use only)
- ☐ FMLA Requested (Certification review – HRSSC)
- ☐ For COP Leave (CA1 on file)
- ☐ For Advanced Sick Leave (PS 1221 on file)
- ☐ For Military Leave (Orders reviewed)
- ☐ For Court Leave (Summons reviewed)
- ☐ For Higher Level (PS 1723 on file)
- ☐ Scheme Training Testing Qualifying (Memo on file)

Revised Schedule for (Date) | Approved in Advance ☐ Yes ☐ No

Begin Work | Lunch Out | Lunch In | End Work | Total Hours

Remarks (Do not enter medical information. See Privacy Act Statement on reverse of this form.)

IOD - No work available within medical restrictions. Please convert any leave used and time lost during the first 45 days to COP.

I understand that the annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP.

Employee's Signature and Date	Signature of Person Recording Absence and Date	Signature of Supervisor and Date Notified
Donald Duck 1/08/22		Cruella de Vil 1/08/22

Official Action on Application (Return copy of signed request to employee.)

SCHEDULED	UNSCHEDULED	PP	Year		
				Day	Init.	Hours
				Sat 01		
				Sun 02		
				Mon 03		
				Tue 04		
				Wed 05		
				Thur 06		
				Fri 07		
				Sat 08		
				Sun 09		
				Mon 10		
				Tue		

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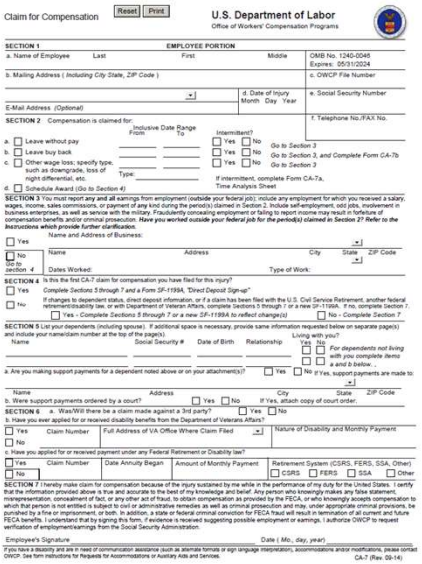
Form CA-7 –
Claim for Compensation


Claim for Compensation

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

SECTION 1 EMPLOYEE PORTION

a. Name of Employee Last First Middle

OMB No. 1240-0046
Expires: 05/31/2024

b. Mailing Address (*Including City State, ZIP Code*)

c. OWCP File Number

E-Mail Address (Optional)

d. Date of Injury Month Day Year

e. Social Security Number

f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

Inclusive Date Range From To

Intermittent?

a. ☐ Leave without pay ☐ Yes ☐ No *Go to Section 3*

b. ☐ Leave buy back ☐ Yes ☐ No *Go to Section 3, and Complete Form CA-7b*

c. ☐ Other wage loss; specify type, such as downgrade, loss of night differential, etc. Type: ☐ Yes ☐ No *Go to Section 3*

If intermittent, complete Form CA-7a, Time Analysis Sheet

d. ☐ Schedule Award (*Go to Section 4*)

SECTION 3 You must report **any and all** earnings from employment (outside your federal job); include any employment for which you received a salary, wages, income, sales commissions, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, odd jobs, involvement in business enterprises, as well as service with the military. Fraudulently concealing employment or failing to report income may result in forfeiture of compensation benefits and/or criminal prosecution. ***Have you worked outside your federal job for the period(s) claimed in Section 2? Refer to the instructions which provide further clarification.***

Name and Address of Business:

☐ Yes

☐ No *Go to section 4*

Name Address City State ZIP Code

Dates Worked: Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?

☐ Yes *Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"*

☐ No If changes to dependent status, direct deposit information, or if a claim has been filed with the U.S. Civil Service Retirement, another federal retirement/disability law, or with Department of Veteran Affairs, complete Sections 5 through 7 or a new SF-1199A. If no, complete Section 7.

☐ Yes - *Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)* ☐ No - *Complete Section 7*

SECTION 5 List your dependents (including spouse). If additional space is necessary, provide same information requested below on separate page(s) and include your name/claim number at the top of the page(s).

Name Social Security # Date of Birth Relationship Living with you? Yes No

☐ ☐ *For dependents not living with you complete items a and b below.*

a. Are you making support payments for a dependent noted above or on your attachment(s)? ☐ Yes ☐ No If Yes, support payments are made to:

Name Address City State ZIP Code

b. Were support payments ordered by a court? ☐ Yes ☐ No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? ☐ Yes ☐ No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

☐ Yes Claim Number Full Address of VA Office Where Claim Filed Nature of Disability and Monthly Payment

☐ No

c. Have you applied for or received payment under any Federal Retirement or Disability law?

☐ Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (CSRS, FERS, SSA, Other)

☐ No ☐ CSRS ☐ FERS ☐ SSA ☐ Other

SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief. 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 criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for FECA fraud will result in termination of all current and future FECA benefits. I understand that by signing this form, if evidence is received suggesting possible employment or earnings, I authorize OWCP to request verification of employment/earnings from the Social Security Administration.

Employee's Signature Date (*Mo., day, year*)

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form instructions for Requests for Accommodations or Auxiliary Aids and Services. CA-7 (Rev. 09-14)

NALC 74TH BIENNIAL CONVENTION
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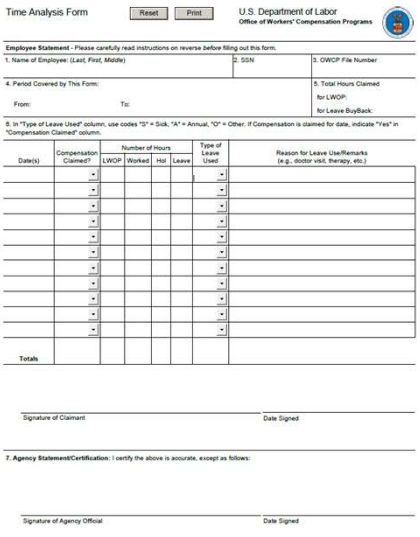
Form CA-7a –
Time Analysis Form


Time Analysis Form

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

Employee Statement - Please carefully read instructions on reverse *before* filling out this form.

1. Name of Employee: (*Last, First, Middle*) 2. SSN 3. OWCP File Number

4. Period Covered by This Form:

From: To:

5. Total Hours Claimed for LWOP: for Leave BuyBack:

6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours LWOP	Worked	Hol	Leave	Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
Totals							

Signature of Claimant Date Signed

7. **Agency Statement/Certification:** I certify the above is accurate, except as follows:

Signature of Agency Official Date Signed

NALC 74TH BIENNIAL CONVENTION
AUGUST 3-7, 2026

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CA-7 and CA-7a

- Postal Service is responsible for ensuring the form is complete
- Compensation paid by OWCP
- Carrier should submit a direct deposit form (**SF-1199**)
- PS Forms 3971s – document lack of work

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CA-7 and CA-7a

- Up to 4 hours for an appointment/treatment
- Up to 8 hours for epidural injections
- PS Form 3971s – document medical treatment

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PS Form 3971 – LWOP

UNITED STATES POSTAL SERVICE®

Request for or Notification of Absence

Employee's Name (Print last, first, MI.)	Employee ID	Date Submitted (MM/DD/YYYY)	No. of Hours Requested
Duck, Donald P	012 55 346	2/18/2022	80

Installation (For postmaster's leave, show city, state, and ZIP Code)	N/S Day	Pay Loc. No.	D/A Code	From: Date	Hour
Disneyland Post Office		201		2/08/2022	8:00 AM

Time of Call or Request	Scheduled Reporting Time	If Needed, Employee Can Be Reached At:	Thru: Date	Hour
	8:00 AM	☐ Do not call	2/18/2022	4:30 PM

Type of Absence
- ☐ Annual
- ☐ Holiday/AL Lv Exch
- ☐ Carrier 701 Route
- ☒ LWOP (See reverse)
- ☐ Sick (See reverse)
- ☐ Late
- ☐ COP (See reverse)
- ☒ Other OWCP (049)

Documentation (For official use only)
- ☐ FMLA Requested (Certification review – HRSSC)
- ☐ For COP Leave (CA1 on file)
- ☐ For Advanced Sick Leave (PS 1221 on file)
- ☐ For Military Leave (Orders reviewed)
- ☐ For Court Leave (Summons reviewed)
- ☐ For Higher Level (PS 1723 on file)
- ☐ Scheme Training Testing Qualifying (Memo on file)

Revised Schedule for (Date) | Approved in Advance ☐ Yes ☐ No

Begin Work | Lunch Out | Lunch In | End Work | Total Hours

Remarks (Do not enter medical information. See Privacy Act Statement on reverse of this form.)

IOD - No work available within medical restrictions.

I understand that the annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP.

Employee's Signature and Date	Signature of Person Recording Absence and Date	Signature of Supervisor and Date Notified
Donald Duck 2/18/22		Cruella de Vil 2/18/22

Official Action on Application *(Return copy of signed request to employee.)*
- ☐ Approved
- ☐ Disapproved (Give reason below)

Do not check an FMLA box until you verify the FMLA designation.
- ☐ FMLA Designation is PENDING

Signature of Supervisor and Date

SCHEDULED / UNSCHEDULED

PP | Year

Day	Init.	Hours
Sat 01		
Sun 02		
Mon 03		
Tue 04		
Wed 05		
Thur 06		
Fri 07		
Sat 08		
Sun 09		
Mon 10		
Tue 11		
Wed 12		
Thur		

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CA-7 – Wage Loss Compensation (WLC)

< Employee with less than 11 months

- CCAs receive compensation based on FECA Bulletin 13-03
- PTFs receive compensation based on 5 USC 8114

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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CA-7 – Wage Loss Compensation (WLC)

>Employee with more than 11 months

- CCAs receive compensation based on FECA Bulletin 13-03
- PTFs receive compensation based on 5 USC 8114

NALC 74TH BIENNIAL CONVENTION AUGUST 3-7, 2026

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ACT VI – LDJO

Limited Duty Job Offers

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CA-17 – Duty Status Report

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

1. Employee's Name (Last, first, middle): Duck, Donald
2. Date of Injury (Month, day, yr.): 12/24/2025
3. Social Security Number: 123-45-6789
4. Occupation: City Carrier
5. Describe How the Injury Occurred and State Parts of the Body Affected: Carrier hurt back lifting box
6. The Employee Works: Hours Per Day 8 Days Per Week 5
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. 35	#lbs. 70	8 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

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: Lumbar disc herniation
10. Diagnosis(es) Due to Injury: M21.26
11. Other Disabling Conditions: Carpal tunnel
12. Employee Advised to Resume Work? ☒ Yes, Date Advised 3/05/2026 ☐ No
13. Employee Able to Perform Regular Work Described on Side A? ☐ Yes, If so ☐ Full-Time or ☐ Part-Time 8 Hrs Per Day ☒ No, If not, complete below:

	Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs. 5	#lbs. 5	6 Hrs Per Day
b. Sitting	☐	☒	8 Hrs Per Day
c. Standing	☐	☒	2 Hrs Per Day
d. Walking	☐	☒	2 Hrs Per Day
e. Climbing	☒	☐	1 Hrs Per Day
f. Kneeling	☐	☐	Hrs Per Day

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CA-17 – Medical Restrictions

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LDJO – Time - Law

20 CFR § 10.507 How should the employer make an offer of suitable work?

Where the attending physician or OWCP notifies the employer in writing that the employee is partially disabled (that is, the employee can perform some work but not return to the position held at date of injury), the employer should act as follows:

(a) If the employee can perform in a specific alternative position available in the agency, and the employer has advised the employee in writing of the specific duties and physical requirements, ***the employer shall notify the employee in writing immediately of the date of availability.*** (emphasis added)

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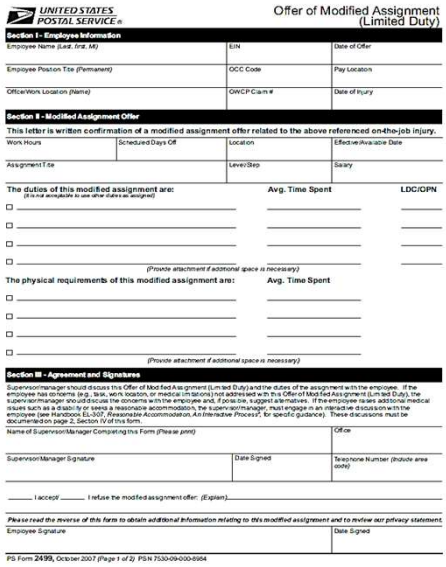
PS Form 2499



UNITED STATES POSTAL SERVICE®

Offer of Modified Assignment (Limited Duty)

Section I - Employee Information

Employee Name (Last, first, MI) | EIN | Date of Offer

Employee Position Title (Permanent) | OCC Code | Pay Location

Office/Work Location (Name) | OWCP Claim # | Date of Injury

Section II - Modified Assignment Offer

This letter is written confirmation of a modified assignment offer related to the above referenced on-the-job injury.

Work Hours | Scheduled Days Off | Location | Effective/Available Date

Assignment Title | Level/Step | Salary

The duties of this modified assignment are: (It is not acceptable to use other duties as assigned) | Avg. Time Spent | LDC/OPN

☐ _____ _____ _____

☐ _____ _____ _____

☐ _____ _____ _____

☐ _____ _____ _____

(Provide attachment if additional space is necessary)

The physical requirements of this modified assignment are: | Avg. Time Spent

☐ _____ _____

☐ _____ _____

☐ _____ _____

☐ _____ _____

(Provide attachment if additional space is necessary)

Section III - Agreement and Signatures

Supervisor/manager should discuss this Offer of Modified Assignment (Limited Duty) and the duties of the assignment with the employee. If the employee has concerns (e.g., task, work location, or medical limitations) not addressed with this Offer of Modified Assignment (Limited Duty), the supervisor/manager should discuss the concerns with the employee and, if possible, suggest alternatives. If the employee raises additional medical issues such as a disability or seeks a reasonable accommodation, the supervisor/manager, must engage in an interactive discussion with the employee (see Handbook EL-307, *Reasonable Accommodation, An Interactive Process*", for specific guidance). These discussions must be documented on page 2, Section IV of this form.

Name of Supervisor/Manager Completing this Form (Please print) | Office

Supervisor/Manager Signature | Date Signed | Telephone Number (Include area code)

_____ I accept/ _____ I refuse the modified assignment offer. (Explain)_____

Please read the reverse of this form to obtain additional information relating to this modified assignment and to review our privacy statement.

Employee Signature | Date Signed

PS Form **2499**, October 2007 (Page 1 of 2) PSN 7530-09-000-8964

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PS Form 2499 – *Offer of Modified Assignment*

(Limited Duty) identifies:

- Scheduled Hours
- Scheduled Days
- Salary
- Duties

ELM 545.32 describes what is needed for a suitable job offer.

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PS Form 2499

UNITED STATES POSTAL SERVICE®

Offer of Modified Assignment (Limited Duty)

Section I - Employee Information

Employee Name (Last, first, MI)	EIN	Date of Offer
Duck, Donald P	012 55 346	2/28/2022
Employee Position Title (Permanent)	**OCC Code**	**Pay Location**
City Carrier	P-2310	201
Office/Work Location (Name)	**OWCP Claim #**	**Date of Injury**
Disneyland Post Office	123 456 789	12/24/2021

Section II - Modified Assignment Offer

This letter is written confirmation of a modified assignment offer related to the above referenced on-the-job injury.

Work Hours	Scheduled Days Off	Location	Effective/Available Date
8:00AM - 4:30PM	Rotating	Disneyland PO	3/05/2022
Assignment Title		**Level/Step**	**Salary**
Modified City Carrier		O	$ 70,039

The duties of this modified assignment are: (It is not acceptable to use other duties as assigned)	Avg. Time Spent	LDC/OPN
☐ Case route	up to 2 hours	722
☐ Maintain Redbooks	about an hour	722
☐ Customer Connect	about 2 hours	
☐ E 360 calls and follow-up	about an hour	

(Provide attachment if additional space is necessary.)

The physical requirements of this modified assignment are:	Avg. Time Spent
☐ lifting up to 5 lbs	up to 6 hours
☐ sitting	up to 8 hours
☐ standing	about 2 hours
☐ walking	about an hour

(Provide attachment if additional space is necessary.)

Section III - Agreement and Signatures

Supervisor/manager should discuss this Offer of Modified Assignment (Limited Duty) and the duties of the assignment with the employee. If the employee has concerns (e.g., task, work location, or medical limitations) not addressed with this Offer of Modified Assignment (Limited Duty), the supervisor/manager should discuss the concerns with the employee and, if possible, suggest alternatives. If the employee raises additional medical issues such as a disability or seeks a reasonable accommodation, the supervisor/manager, must engage in an interactive discussion with the employee (see Handbook EL-307, *Reasonable Accommodation, An Interactive Process*", for specific guidance). These discussions must be documented on page 2, Section IV of this form.

Name of Supervisor/Manager Completing this Form (Please print)		Office
Cruella de Vil		Disneyland PO
Supervisor/Manager Signature	**Date Signed**	**Telephone Number (Include area code)**
Cruella de Vil	2/28/2022	949-555-4355

X I accept/ _____ I refuse the modified assignment offer: *(Explain)* accept under protest - pending doctor review

Please read the reverse of this form to obtain additional information relating to this modified assignment and to review our privacy statement.

Employee Signature	Date Signed
Donald Duck	3/01/2022

PS Form **2499**, October 2007 *(Page 1 of 2)* PSN 7530-09-000-8984

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PS Form 2499

Employee Name *(Last, first, MI)*	EIN	Date of Offer
Duck, Donald P	012 55 346	2/28/2022

Employee Information - Offer of Modified Assignment (Limited Duty)

This assignment will remain within the physical restrictions furnished by your treating physician. You are advised not to exceed these restrictions. This assignment is currently available and is subject to revision based on changes in your physical restrictions and/or the availability of adequate work. If a revision is necessary, you will be given a revised written modified assignment. Indicate your decision in the appropriate box located at the bottom of the assignment offer. If you refuse this modified assignment offer, the Office of Workers' Compensation Programs (OWCP) will be advised for whatever action they deem appropriate.

This modified assignment offer has been prepared and is offered to you in accordance with guidelines outlined in the *Employee and Labor Relations Manual*, Part 540, and 20 CFR Part 10. If you have any questions regarding this matter, please contact your designated Health and Resource Management Control Office.

Privacy Act Statement:

Your information will be used to offer a modified assignment. Collection is authorized by 39 U.S.C. 401, 410, 1001, 1005, and 1206.

Providing the information is voluntary, but if not provided, we may not process this modified assignment offer. We may only disclose your information as follows: in relevant legal proceedings; to law enforcement when the US Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; to your private treating physician and to medical personnel retained by the USPS to provide medical services in connection with your health or physical condition related to employment.

IV. Documentation

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Limited Duty Job Offer (LDJO)

Postal and federal regulations allow the injured worker to take the job offer to their attending physician.

When in doubt, accept any job offer and write **"under protest"** next to your signature. Then, schedule an appointment with your treating physician as soon as possible.

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Limited Duty Job Offer (LDJO)

Injured workers who get a job offer with some duties exceeding their medical limitations, should accept the job offer, do what work they feel is within their medical limitations, and take the job offer to their physician for review.

Never work beyond your accepted medical restrictions!!

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LDJO – Ergonomics

- *"When an employee is returning to work from an on-the-job injury, an ergonomic evaluation is often required to ensure the job meets any restrictions or limitations the employee might have."* Postal Bulletin 22617 (2/09/2023)
- Raising the work with equipment, such as a pallet lifter or a container tilter to eliminate bending and overreaching when unloading packages or mail trays.

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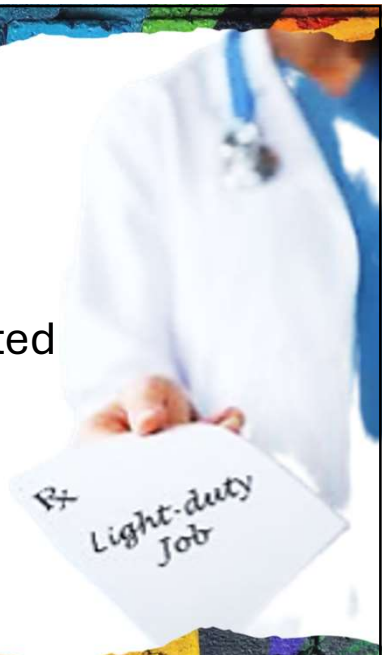
LDJO – Medical Suitability

- **Only** OWCP can decide whether a limited duty job offer is medically suitable
- Limited duty job offer outside Postal handbooks and manuals is grievable



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LDJO – Medical Suitability

- "*…OWCP must consider both preexisting and subsequently-acquired conditions in the evaluation the suitability of an offered position.*"
(ECAB 71-0222, December 21, 2018; see also, Richard P. Cortes, 56 ECAB 200 (2004) (04-1561)) (emphasis added)
- "*The Federal (FECA) Procedure Manual provides that "[i]f medical reports in the file document a condition which has arisen since the compensable injury, and this condition disables the claimant from the offered job, the job will be considered unsuitable (even if the subsequently-acquired condition is not work related).*"
(Martha A. McConnell, 50 ECAB 129 (1998). Regarding the consideration of subsequently acquired conditions, see Federal (FECA) Procedure Manual, Part 2 --Claims, Reemployment: Determining Wage-Earning Capacity, Chapter 2.814.4b(4) (December 1993)) (emphasis added)

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LDJO – Obligation

ELM 546.142 Obligation

*When an employee has partially overcome a compensable disability, the Postal Service **must make every effort** toward assigning the employee to limited duty consistent with the employee's medically defined work limitation tolerance* (see 546.611).

LDJO – Obligation

EL-505 - Exhibit 7.1 Limited Duty Assignment Guidelines (page 145-148)

Limited duty does not have to be requested, rather it is made available and offered.

Whenever possible, assign qualified employees to limited duty in their regular craft, during regular tour of duty, and in their regular work facility.

EL-505 – Priority for Assignment (ELM 546.142)

Priority of Choice	Regular Craft	Regular Tour	Regular Facility
1st	Within	Within	Within
2nd	Outside	Within	Within
3rd	Within	Outside	Within
4th	Outside	Outside	Within
5th	Within	Within	Outside
6th	Outside	Within	Outside
7th	Within	Outside	Outside
8th	Outside	Outside	Outside

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Penalty – Law Citation

18 USC § 1922 - False or withheld report concerning Federal employees' compensation

Whoever, being an officer or employee of the United States charged with the responsibility for making the reports of the immediate superior specified by section 8120 of title 5, willfully fails, neglects, or refuses to make any of the reports, or knowingly files a false report, or induces, compels, or directs an injured employee to forego filing of any claim for compensation or other benefits provided under subchapter I of chapter 81 of title 5 or any extension or application thereof, or willfully retains any notice, report, claim, or paper which is required to be filed under that subchapter or any extension or application thereof, or regulations prescribed thereunder, shall be fined under this title or imprisoned not more than one year, or both. (emphasis added)

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Penalty – ELM Citation

ELM 542.33 – Penalty for Refusal to Process Claim

Any employee or supervisor responsible for making reports in connection with an injury who willfully fails, neglects, or refuses to do so; induces, compels, or directs an injured employee to forego filing a claim; or ***willfully retains any notice, report, or paper required in connection with an injury may be subject to a fine of not more than $500 or 1 year in prison, or both.*** (emphasis added)

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ACT VII – Schedule Awards

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Schedule Award

- Have an accepted OWCP claim
- Reached MMI
- Suffer permanent impairment to a scheduled body part or function
- Acquire and submit the necessary medical report
- Claim Schedule Award

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Viewed in Terms of Extremities

Upper extremities	Lower extremities
Hand	Foot
Wrist	Ankle
Elbow	Knee
Shoulder	Hip

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Pre-existing Conditions

Example: *If an aggravation of left hip osteoarthritis is accepted as work-related but the claimant also suffers from non-industrial left knee osteoarthritis, both of which have resulted in permanent impairment, an assessment of impairment should reflect the total loss of the left leg, to include both the industrial and non-industrial injuries.*

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Compensation Schedule

FORMULA:

(# WEEKS) **X**

(% IMPAIRMENT) **X**

(PAY RATE) **X**

(⅔ OR ¾) =

SCHEDULE AWARD

BODY PART	# WEEKS
Arm	312
Leg	288
Hand	244
Foot	205
Penis	205
Vulva/Vagina	205
Uterus/Cervix	205
Skin	205
Hearing (Both ears)	200
Larynx/Tongue	160
Eye	160
Kidney/Lung	156
Thumb	75
Hearing (1 ear)	52
Testicle	52
Breast	52
Ovary (includes fallopian tubes)	52
1st Finger	46
Great toe	38
2nd Finger	30
3rd Finger	25
Other toe	16
4th Finger	15

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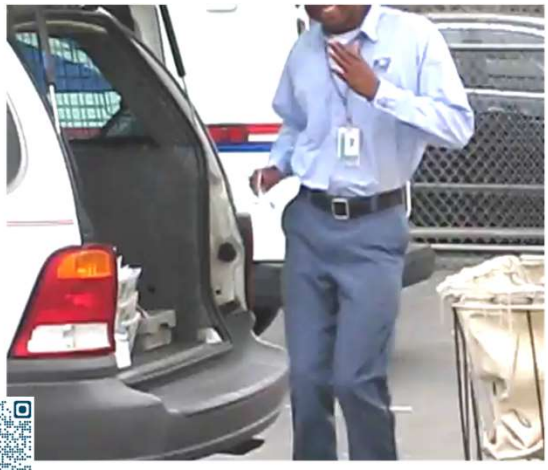
SHOW ME THE MONEY!



- ✗ Federal Civilian Employees and Union Officials are prohibited from accepting money for OWCP Representation
- ✓ We assist Union members for **free**

North Carolina – "Dancing Mailman" (https://youtu.be/-zABC_Xg07o)

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RESOURCES

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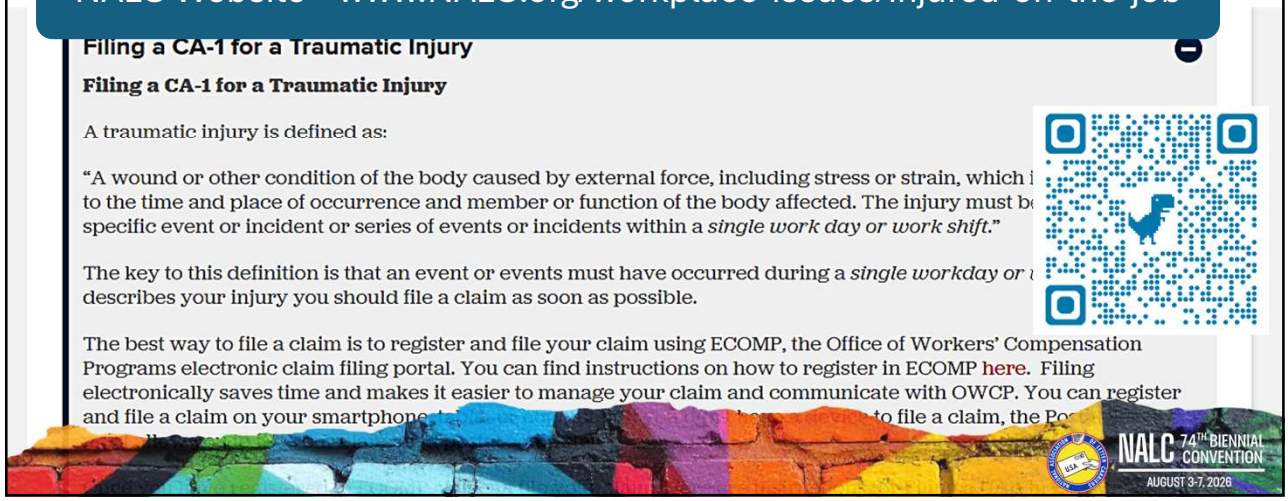
Resources

NALC Website – www.NALC.org/workplace-issues/injured-on-the-job



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Resources

NALC APP - *Injured on the job*

OWCP Website

https://www.dol.gov/agencies/owcp/FECA

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Resources – NBA's Office

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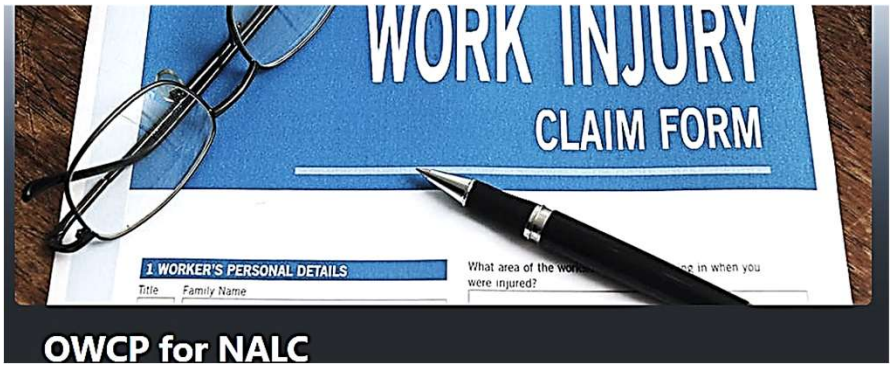
NALC – OWCP Facebook Group



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NALC's OWCP Facebook Group

NALC's group monitored by:

- **RWCA Anita Lewallen** (Regions 6 & 8)
- **RAA Larissa Parde** (Region 5)
- **RWCA David Miller** (Regions 4 & 10)
- **Prior RWCA Doug Lawrence**
- **RWCA Willie Groshell** (Regions 2 and 11)

If you need advice on Facebook, go to the group specifically designed to respond to NALC members.

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