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Employing Agency Portion For first CA-7 claim sent, complete sections 8 through 15. For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show F	Pay Rate as of		ional Pay		ditional Pa	•	i .		ional F	Pay	
Date of Injury:	Base Pay		Nite Diff	Тур	e	_	'	Type _			
Date: $\frac{11}{GS} \frac{1}{9} \frac{20}{3} \frac{02}{3}$	31.15 per hour	\$\$	per <u>nour</u>	\$	per_		\$_		per		
Grade: GS 9 Step: 3											
Date Employee Stopped World	k:	Type	Nite Diff	Тур	е			Туре			
Date: 1 / 6 / 03	32.15 per hour	\$ 6.15	per <u>hour</u>	\$	per_		\$_		per		
Date: 1 / 6 / 03 Grade: GS 9 Step: 3											
Additional pay types include, but (SUB), Quarters (QTR), etc. (List	are not limited to: Nigh	t Differentia	al (ND), Sunday	Premiur	n (SP), Ho	liday Pr	emiur	n (HP), Sub	siste	ence
SECTION 9											
a. Does employee work a fixed	40-hour per week sched	ule? Yes	No 🗆								
 If Yes, circle scheduled da 	ays: S 🤇	M T	W TH								
2. If No, show scheduled ho	urs for the two week pay	y period in v	which work stop	ped. Cir	cle the da	y that wo	ork sto	pped	l.		
FOR EXA	MPLE ONLY		Intermi	ttent II	- 92						
[3	M T W TH	F S	merm	ttent O		S M	T	W	TH	F	S
WEEK 1 From <u>5/14</u> to <u>5/20</u>	8 4 6 6		WEEK 1 From	to _							
WEEK 2	8 6 6	4	WEEK 2								
From <u>5/21</u> to <u>5/27</u>		النا	From	to _	L		1				
b. Did employee work in position	for 11 months prior to	injury?	Ă Yes 🗌	No							
If No, would position have afforde			or the injury?		Yes 🗆	No					
SECTION 10 On date pay sto	noned was employee e	nrolled in:									
a Health Reposite		· ·	Optional Life Ins	surance?	□ No [Yes	Class		D		
under the FEHBP?	Yes Code	211	A D-#:		□ No E	V	Dian	FF	(D-Z	only)	
b. Basic Life Insurance?		a. /	A Retirement Sy	/stem?	□ NO L	⊥ res (Specif	y CSF	S, FEF	9 <i>S,</i> C	Other)
SECTION 11 Continuation of	Pay (COP) Received (Show inclus	ive dates):		Пуе	s — Con	nnlete	Time			
Park Charles				termittent		alysis Si				ι	
From	To 1 / 05 /				X No						
SECTION 12 Show pay statu	s and inclusive dates for	r period(s)	claimed:	Intermit	tent?			D	UAL	FC	R M
A CONTRACTOR OF	/ / To_			Yes	□ No	If inte	rmitte	nt, co	mplete	•	$\overline{}$
Annual Leave From				Yes	□ No			a, Tim	e Ana	lysis	· /
Leave without Pay From					□ No	Sheet					Zu.
	/ / To_				□ No				, also CA-7b		mı
SECTION 13 Did employee r			No ·			,					
If Yes, date	/ /	63 [110								
If returned, did employee return to	to the pre-date-of-injury	job, with th	e same number	of hours	and the s	ame dul	ties?				
☐ Yes ☐ No If No, exp	olain: NA										
SECTION 14 Remarks:											
	NA										
SECTION 15 An employing a	agency official who know this claim may also be	vingly certification	es to any false	statemer	nt, misrepr	esentati	on, or	conc	ealme	nt of	fact,
I certify that the information give exceptions noted in Section 14, I	n above and that furnish						of my	know	ledge,	with	any
Signature U. R. Right			-u St	r. Inspe	ctor				12 ,	20 1	02
- 3			i ma	· Inspec	LIUI		Г)ate	L2 / .	-·,	
Dont of Age	(Agency Official)		inte	· Hisper			[Date _			
Name of Agency Dept of Agra	iculture	should be		· Inspec				Date _			
Name of Agency Dept of Agra If OWCP needs specific pay info Jane Jones	iculture	should be	contacted is:		esources		[Date _			

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R.10.106.

EMPLOYEE (or person acting on the employee's behalf) — Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) — Complete sections 8 through 15 as directed and promptly forward the form to OWCP.

EXPLANATIONS — Some of the items on the form which may require further clarification are explained below:

Section Number	Explanation
2d. Schedule Award	Schedule awards are paid for permanent impairment to a member or function of the body.
5. List your dependents	Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he or she either lives with you or receives support payments from you, and he or she: 1) is under 18; or 2) is between 18 and 23 and is a full-time student; or 3) is incapable of self-support due to physical or mental disability.
6a. Was/will there be a claim made against 3rd 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 who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury.
8. Additional Pay	"Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported.
11. Continuation of pay (COP) received	If the injury was not a traumatic injury reported on Form CA-1, this item does not apply.
14. Remarks	This space is used to provide relevant information which is not present elsewhere on the form.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.