OWCP MUST HAVES

NALC Branch 248

https://nalcbranch248.com/

INJURED? WE'RE HERE FOR YOU !

- ….. The NALC is committed to ensuring that every member who needs help with an OWCP claim receives it"

https://www.nalc.org/workplace-issues/injured-on-the-job

- Today, Before any injury occurs, everyone should register now!!

https://www.ecomp.dol.gov/#/

WHATS REQUIRED TO SIGN UP FOR ECOMP

For assistance in registering for an ECOMP account with OWCP, please provide the following information. (Please Print)

Name:_____

Cell Phone#:_____

Email:_____

Date of Birth:_____

Home Address:_____

_____

***Upon registering you will be asked to enter your social security number and to choose a password. The password must contain at least 8 characters that contain at least:**

1. **One uppercase letter**
2. **One lowercase letter**
3. **One number**
4. **One Special Character (For example: @, #, $,)**

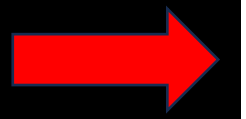
Please choose a password before getting assistance with registration to expedite the process.

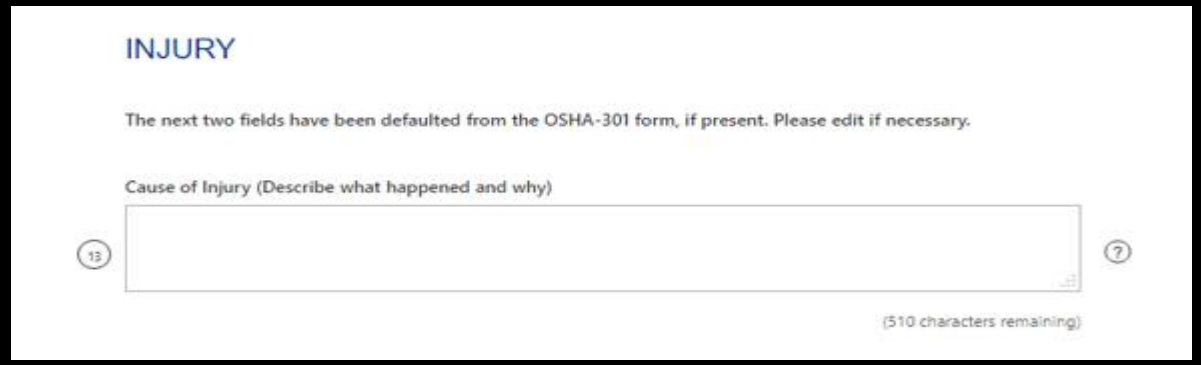
If you would like to register on your own, scan the QR Code below and follow the instructions.

WHAT TO DO IF YOU GET INJURED?

- Report injury immediately to your immediate supervisor
- File a CA-1 on ecomp - request COP
- Request CA-16 & CA-17 from supervisor
- Seek medical attention (MD of choice)
- Make sure medical reports are signed by an MD
- Follow physician’s restrictions
- Provide copy of CA-17 to management
- Inform your union steward/president/OWCP rep

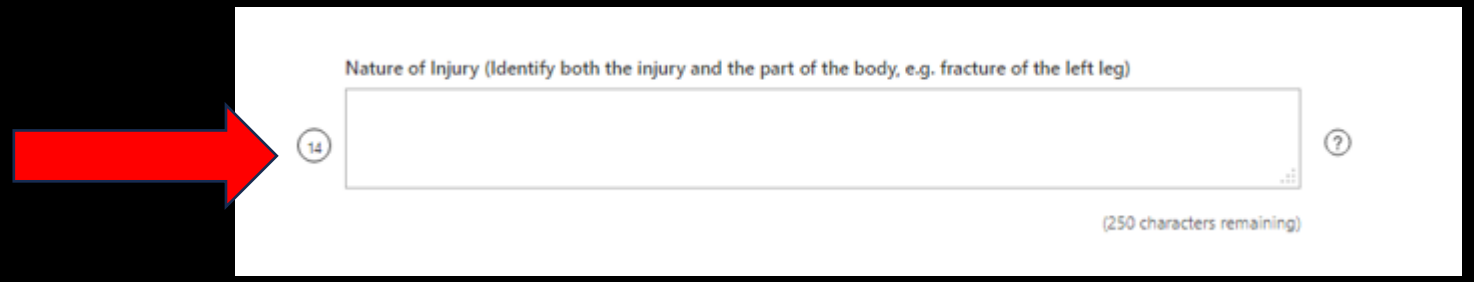
You will need a description of the injury (Slip, trip, fall, uneven surfaces, weather conditions…….510 characters NO POSTAL SLANG) **Write down what happened. The description of your injury will need to be filled out in question 13 of your CA-1**





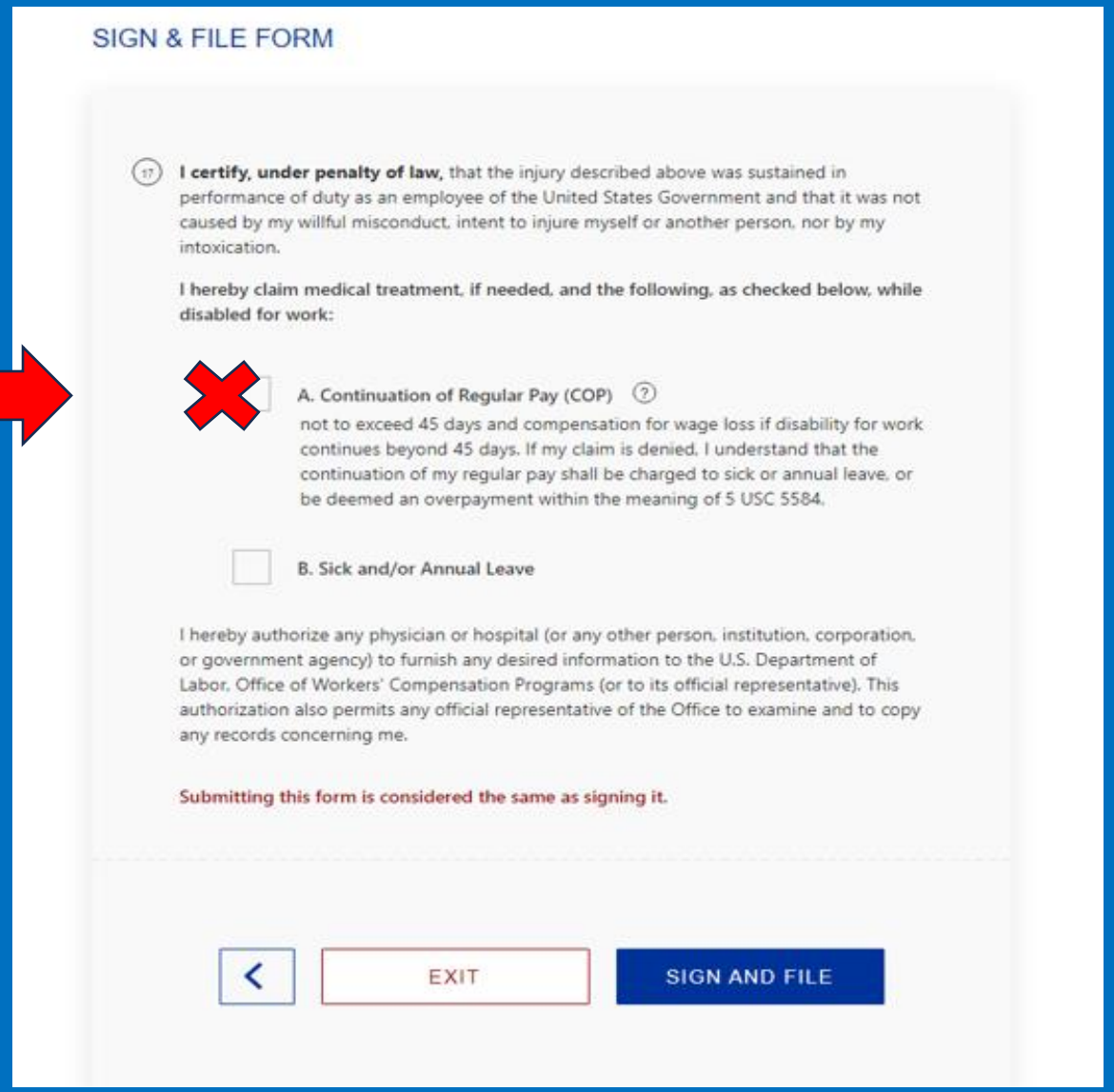
Whatever you stated/claimed in item 13 of your CA-1 must be what you tell your doctor at the time treatment is rendered.

You will need to then complete item 14 of the CA-1 “Nature of injury”



This is completed by describing <u>all</u> body parts affected by the claimed injury.

The most important thing to do next is check COP sign and file



- WHY DO YOU WANT TO REQUEST CONTINUATION OF PAY (COP)?

Paid directly by USPS

COP payable for a maximum of 45 calendar days

Time not worked on day of injury does NOT count towards COP, absence is paid as administrative leave for the hours scheduled to work

Annual and sick leave benefits will continue to accrue. All regular deductions and contributions will continue.

CA-16 TIMELINE After Injury

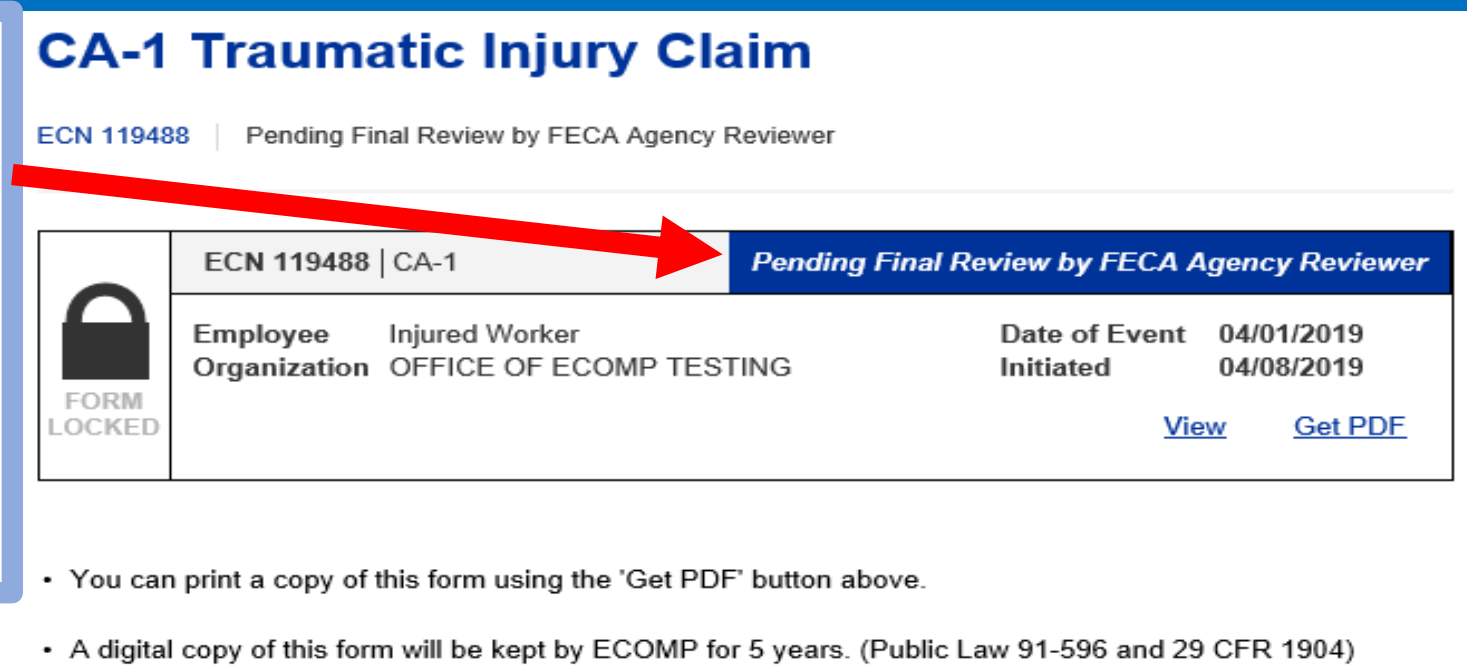
Form – 4 Hours

Verbal – 48 Hours

The employer is not required to issue a Form CA-16 more than one week after the occurrence of the claimed injury.

ECOMP Supervisor Dashboard – CA-16

After the supervisor sends the form to the "Agency Reviewer."



NO EXCUSES for failing to provide CA-16

*By clicking "ISSUE CA-16," a PDF of the form downloads or prints

Management Fills out

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: 08/31/2026

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		Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day	#lbs.	#lbs.	Hrs Per Day
b. Sitting	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
c. Standing	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
d. Walking	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
e. Climbing	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
f. Kneeling	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
g. Bending/Stooping	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
h. Twisting	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
i. Pulling/Pushing	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
j. Simple Grasping	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
k. Fine Manipulation (includes keyboarding)	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
l. Reaching above Shoulder	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
m. Driving a Vehicle (Specify)	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
n. Operating Machinery (Specify)	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
o. Temp. Extremes	☐	☐	range in degrees F	☐	☐	range in degrees F
p. High Humidity	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
r. Fumes/Dust (identify)	☐	☐	Hrs Per Day	☐	☐	Hrs Per Day
s. Noise (Give dBA)	☐	☐	dBA Hrs Per Day	☐	☐	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:
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. 04/2020)

Doctor fills out
This is your time for a discussion

FINDING A PROVIDER (MD – DO)

OFFICE OF WORKERS' COMPENSATION PROGRAMS
MEDICAL BILL PROCESSING PORTAL

FAQs | CONTACT US

Search

Home | Provider | Claimant | Login | Resources | Pharmacy/LMN | Contact Us

Home / Provider Home / Find a Provider

The provider search feature allows Department of Labor (DOL), Office of Workers' Compensation Program (OWCP) customers to search for medical providers in their locale. The provider search feature allows searches by: provider type, physician's last name or practice name, physician's first name, city, state, zip code, and specialty. The providers listed in the search feature are actively enrolled with OWCP Workers' Compensation Medical Bill Process (WCMBP) system as a medical provider and have opted to be included in the search feature. A listed provider or services rendered by the provider does not constitute an endorsement by OWCP, nor does it guarantee that the medical provider/facility will be reimbursed by OWCP for specific medical services provided to a particular claimant. The appearance of a specific medical provider's name in the listing does not require that provider to treat a particular claimant, even if OWCP has already advised the claimant in writing that medical treatment for a particular condition within the provider's listed specialty has been authorized.

Agree | Decline

Provider Search

Note: A percent (%) symbol can be used as a wildcard to search if the exact Provider Name is not known or the City may have a different spelling (such as St Louis or Saint Louis)

Program Name: * | NPI: NPI

Please enter either 'First Name/Last Name' Or 'Business Name' for Provider Name match search.

First Name: First Name | Last Name: Last Name | Business Name: Business Name

Provider Type: | Provider Specialty: | State/Territory:

City: City | Zip Code: Zip Code | Radius Within: 0

Search | Reset

Provider List

Medical Documentation

Valid Diagnosis

- Pain is NOT a diagnosis
- Strain/Sprain
- Tear/Rupture
- Herniation

Qualified Physician

- MD or DO MUST sign or countersign
- Nurse Practitioners (NP) and Physician Assistants (PA, PA-C) are not considered qualified
- Most urgent care facilities staff NP/PA

What about Chiropractors

- A chiropractor's opinion constitutes medical evidence only if a diagnosis of subluxation of the spine is made and supported by x-rays

What your medical must provide

What are the requirements for medical reports?

In all cases reported to OWCP, a medical report from the attending physician is required. This report should include:

(a) Dates of examination and treatment;
(b) History given by the employee;
(c) Physical findings;
(d) Results of diagnostic tests;
(e) Diagnosis;
(f) Course of treatment;
(g) A description of any other conditions found but not due to the claimed injury;
(h) The treatment given or recommended for the claimed injury;
(i) The physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;
(j) The extent of disability affecting the employee's ability to work due to the injury;
(k) The prognosis for recovery; and
(l) All other material findings.

A physician's opinion supported by a medical explanation as to how the reported work incident caused or aggravated a medical condition

Keep a copy of everything

Questions ??????

NOW WHAT ????

FILL OUT PS FORM 3971 or Call 1877-477-3273

UNITED STATES POSTAL SERVICE®

Request for or Notification of Absence

Employee's Name *(Last, First, M.I.)*	Employee ID	Date Submitted	No. of Hours Requested

Installation *(For PM leave, show city, state, and ZIP code)*	N/S Day	Pay Loc. #	D/A Code	From Date	Hour

Time of Call or Request	Scheduled Reporting Time	Employee Can Be Reached At *(If needed)* ☐ No Call	Thru Date	Hour

Type of Absence

- ☐ Annual
- ☐ Holiday/AL Lv Exch
- ☐ Carrier 701 Rule
- ☐ LWOP *(See reverse)*
- ☐ Sick *(See reverse)*
- ☐ Late
- ☐ COP
- ☐ Other: _____

Documentation *(For official use only)*

- ☐ For FMLA Leave *(Certification reviewed)*
- ☐ For COP Leave *(CA1 on file)*
- ☐ For Advanced Sick Leave *(1221 on file)*
- ☐ For Military Leave *(Orders reviewed)*
- ☐ For Court Leave *(Summons reviewed)*
- ☐ For Higher Level *(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)*

3 Day Waiting Period

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

Employee's Signature and Date	Signature of Person Recording Absence and Date	Signature of Supervisor and Date Notified

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

- ☐ Approved, not FMLA
- ☐ Approved FMLA, Pending Documentation Noted on Reverse.
- ☐ Approved, FMLA *(See Publication 71)*
- ☐ Disapproved *(Give reason):* _____
- ☐ Ineligible for FMLA *(Estimate eligibility date):* _____

Signature of Supervisor and Date

☐ *Continued on Reverse*

Scheduled	Un-Scheduled	PP Day	Year 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 13		
		Fri 14		

Annual

LWOP

Sick (FTR-PTF)

On the job injury

Employee: Reason I Was Incapacitated for Duty During this Absence

- ☐ Sickness
- ☐ On-the-Job Injury
- ☐ Off-the-Job Injury
- ☐ Pregnancy and Confinement
- ☐ Exposed to a Contagious Disease
- ☐ Undergoing Medical, Dental, or Optical Examination or Treatment *(Job related)*
- ☐ Undergoing Medical, Dental, or Optical Examination or Treatment *(Not job related)*

Reason I Was Unavailable for Duty During This Absence

- ☐ Sick Leave for Dependent Care
- ☐ Birth of Child - Bonding
- ☐ Placement of a Child with Employee for Adoption or Foster Care

Supervisor: Additional Documentation Regarding Denial of Leave Protection Under FMLA

- ☐ Employee Not Eligible -- Less than 1250 Hours Worked.
- ☐ Employee Not Eligible -- Not Employed with USPS 1 Year.
- ☐ Employee Has Exhausted FMLA Entitlement in Current Leave Year.
- ☐ Absence Not for a Covered Condition.
- ☐ Absence Not for a Covered Family Member.
- ☐ Requested Documentation Not Provided.
- ☐ Documentation Provided. Does Not Meet Criteria for FMLA Protection.

Additional Documentation Required

Privacy Act Statement: Your information will be used to administer leave. Collection is authorized by 39 USC 401, 404, 1001, 1003, and 1005; and 29 USC 2601 et seq. Providing the information is voluntary, but if not provided, we may not process your request. Your information may be disclosed as follows: in relevant legal proceedings; to law enforcement when the USPS or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities under contract with USPS and/or authorized to perform audits; to labor organizations as required by law; to government agencies regarding personnel matters; and to the EEOC; MSPB or Office of Special Counsel.

Leave Types *(Information Only)*

Leave Type	CODES Timecard	FMLA/ Dep. Care	Time Clock
Annual – FMLA	55	01	05599
Sick – FMLA	56	02	05699
Sick - Dependent Care	56	07	05697
Absent Without Leave	24		02400
Act of God	78		07800
Blood Donor	69		06900
Civil Defense	77		07700
Civil Disorder	81		08100
COP - USPS	71		07100
COP - USPS - FMLA	71	03	07199
Convention	66		06600
Court Duty	61		06100
Donated - FMLA	46		04600
HQ Authorized Administrative	79		07900
Holiday/AL Leave Exchange	28		02800
LWOP - Part Day	59		05900
LWOP - Full Day	60		06000
LWOP - FMLA - Part Day	59	05	05999
LWOP - FMLA - Full Day	60	06	06099
LWOP - IOD/OWCP-- FMLA	49	04	04999
LWOP - IOD/OWCP - not FMLA	49		04900
LWOP - Lieu of Sick Leave	59 or 60		05901 or 06001
LWOP - Maternity	59 or 60		05905 or 06005
LWOP - Military	44		04400
LWOP - Personal Reasons	59 or 60		05903 or 06003
LWOP - Proffered	59 or 60		05902 or 06002
LWOP - Suspension	59 or 60		05906 or 06006
LWOP - Suspension Pend. Tem.	59 or 60		05908 or 06008
LWOP - Union Official	84		08400
Military	67		06700
Relocation	80		08000
Veteran's Funeral	86		08600
Voting Leave	85		08500
Other Paid	86		08600

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		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 13		
		Fri 14		

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UNITED STATES POSTAL SERVICE®

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Employee's Name *(Last, First, M.I.)*	Employee ID	Date Submitted	No. of Hours Requested

Installation *(For PM leave, show city, state, and ZIP code)*	N/S Day	Pay Loc. #	D/A Code	From Date	Hour

Time of Call or Request	Scheduled Reporting Time	Employee Can Be Reached At *(If needed)*	Thru Date	Hour
		☐ No Call		

Type of Absence
- ☐ Annual
- ☐ Holiday/AL Lv Exch
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- ☐ Late
- ☐ COP
- ☐ Other: _____

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- ☐ For Higher Level *(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)*

OWCP – LWOP Code 049

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

Employee's Signature and Date	Signature of Person Recording Absence and Date	Signature of Supervisor and Date Notified

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

- ☐ Approved, not FMLA
- ☐ Approved FMLA, Pending Documentation Noted on Reverse.
- ☐ Approved, FMLA *(See Publication 71)*
- ☐ Disapproved *(Give reason):* _____
- ☐ Ineligible for FMLA *(Estimate eligibility date):* _____

Signature of Supervisor and Date

☐ *Continued on Reverse*

Scheduled	Un-Scheduled	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 13		
		Fri 14		

LWOP

COP

On the job injury

Employee: Reason I Was Incapacitated for Duty During this Absence

- ☐ Sickness
- ☐ On-the-Job Injury
- ☐ Off-the-Job Injury
- ☐ Pregnancy and Confinement
- ☐ Exposed to a Contagious Disease
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- ☐ Undergoing Medical, Dental, or Optical Examination or Treatment *(Not job related)*

Reason I Was Unavailable for Duty During This Absence

- ☐ Sick Leave for Dependent Care
- ☐ Birth of Child - Bonding
- ☐ Placement of a Child with Employee for Adoption or Foster Care

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- ☐ Absence Not for a Covered Condition.
- ☐ Absence Not for a Covered Family Member.
- ☐ Requested Documentation Not Provided.
- ☐ Documentation Provided. Does Not Meet Criteria for FMLA Protection.

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Leave Types *(Information Only)*

Leave Type	Timecard	CODES FMLA/ Dep. Care	CODES Time Clock
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Sick - Dependent Care	56	07	05697
Absent Without Leave	24		02400
Act of God	78		07800
Blood Donor	69		06900
Civil Defense	77		07700
Civil Disorder	81		08100
COP - USPS	71		07100
COP - USPS - FMLA	71	03	07199
Convention	66		06600
Court Duty	61		06100
Donated - FMLA	46		04600
HQ Authorized Administrative	79		07900
Holiday/AL Leave Exchange	28		02800
LWOP - Part Day	59		05900
LWOP - Full Day	60		06000
LWOP - FMLA - Part Day	59	05	05999
LWOP - FMLA - Full Day	60	06	06099
LWOP - IOD/OWCP-- FMLA	49	04	04999
LWOP - IOD/OWCP - not FMLA	49		04900
LWOP - Lieu of Sick Leave	59 or 60		05901 or 06001
LWOP - Maternity	59 or 60		05905 or 06005
LWOP - Military	44		04400
LWOP - Personal Reasons	59 or 60		05903 or 06003
LWOP - Proffered	59 or 60		05902 or 06002
LWOP - Suspension	59 or 60		05906 or 06006
LWOP - Suspension Pend. Tem.	59 or 60		05908 or 06008
LWOP - Union Official	84		08400
Military	67		06700
Relocation	80		08000
Veteran's Funeral	86		08600
Voting Leave	85		08500
Other Paid	86		08600

Scheduled	Un-Scheduled	PP Day	Year 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 13		
		Fri 14		

Need to upload a document?

Stakeholders and interested parties can use ECOMP to upload documents to active FECA cases. You can upload letters, medical reports and other supporting documentation. You will need the official FECA Case Number and other identifying information to use this feature.

⚠ Do not upload Medical or Travel reimbursement forms (OWCP-915, OWCP-957). Doing so will unnecessarily delay the processing of your reimbursement claim. Medical or Travel reimbursement forms must be mailed to OWCP/DFELHWC-FECA, P.O. Box 8300, London, KY 40742-8300.

UPLOAD DOCUMENTS

https://www.ecomp.dol.gov/#/

Upload Documents to Case

Access case

Case Number

Last Name

Date of Birth *

Select Date

Date of Injury *

Select Date

Instructions

Follow instructions carefully or your documents may not be processed. Need more help? View tutorial.

- Do NOT upload claim forms here.
  For instructions on how to submit an OSHA-301, CA-1, CA-2 or CA-7, click here.
- Do NOT upload medical bills or authorization requests.
  Instead use OWCP's Central Bill Processing Center.
- Do NOT upload claims for reimbursement.
  Submit OWCP-957 & OWCP-915 forms to DFEC's Central Mail Room.
- Do NOT upload upside-down documents.
  Please ensure documents are oriented correctly to view.
- Do NOT upload any Bill Payment issues, CA-7 Status questions, or Request for Authorization inquiries here.
  Please submit an appropriate case escalation from your profile.

UPLOAD A NEW DOCUMENT

Max file size is 5MB

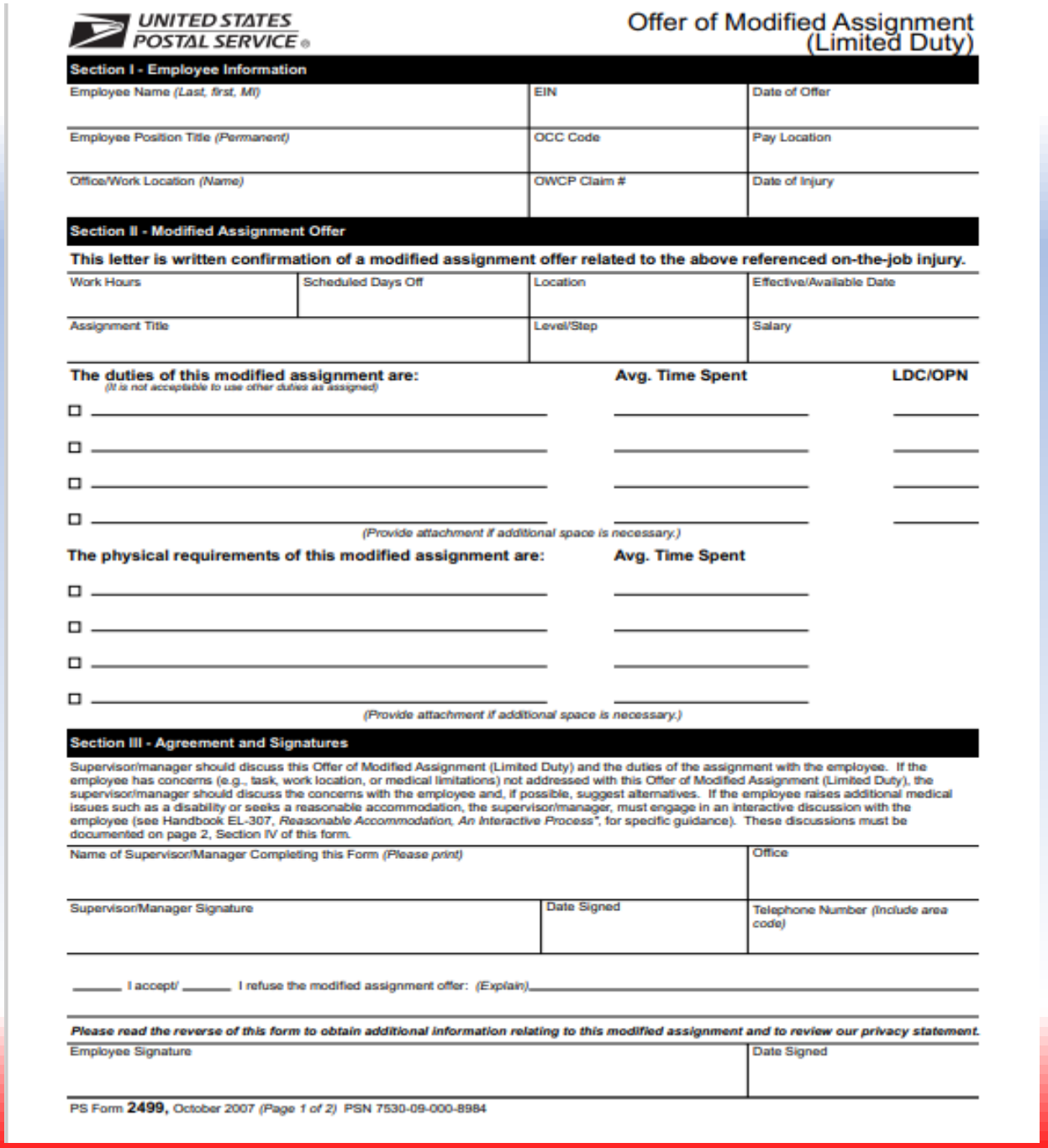
Limit number of pages to 20 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx

CHOOSE A FILE



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

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* Employee's have an obligation to seek and accept work within his/her restrictions

* USPS has legal and contractual obligation to make every effort to provide limited duty

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)*

X 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

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)*

X I accept/ _____ I refuse the modified assignment offer: *(Explain)* UNDER PROTEST SEE ATTACHMENT

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

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

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

Your time to tell the USPS the Union and OWCP why you are denying or protesting the job offer. If part of the job offer duties are within your restrictions state that you will the perform those job duties within your restrictions, but not the job duties outside of your restrictions

Regional Workers' Compensation Assistant
National Association of Letter Carriers Region 9
202-423-2504 (office)
wenger@nalc.org
lester@nalc.org

NALC Branch 248
https://nalcbranch248.com/