Report of Termination of Disability and/or Payment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Part - A General

1. Name of Injured Employee (last, first, middle)	2. Social Security Number	3. OWCP File Number (If known)

4. Department or Agency	5. Bureau or Office

6. Name and Address of Reporting Office (Include Zip Code)

7. Date and Hour of Injury (Mo., day, year)	8. Date and Hour Stopped Work (Mo., day, year)	9. Date and Hour Pay Stopped (Mo., day, year)	10. Date and Hour Returned to Work (Mo., day, year)
☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday

S M T W T F S

12. Present Pay Rate If Different From That Received At Time Employee Stopped Work.

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:

a. Annual Leave	b. Sick Leave	c. Other (Specify)
From: Through:	From: Through:	From: Through:

14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury?

☐ Yes ☐ No If Yes, Describe The Type of Work Employee Is Performing.

15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year)

Health Benefit Optional Insurance

16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year)

Number _____ Date _____

17. Remarks:

Part - B Continuation of Pay

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year)

From: Through:

19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave.

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20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)

21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New Rate

a. Base Pay	b. Subsistence	c. Quarters	d. Other (Specify)

22. Signature of Supervisor	23. Title and Office Phone Number	24. Date (Mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-3
WHEN EMPLOYEE RETURNS TO WORK

PART - A

REQUIRED WRITTEN REPORT

- When disability ceases and/or employee returns to work, the official superior shall immediately report that fact to the OWCP on Form CA-3 unless this information has been previously submitted on Form CA-1 or CA-2 or otherwise. This form should be submitted for each injury resulting in time lost from work whether or not claim for compensation is made.

TELEPHONE/ TELEGRAPH REPORT

- If the employee is receiving disability compensation periodically each four weeks, the official superior should immediately telephone or telegraph the OWCP advising the date employee returned to work. This will avoid an overpayment of compensation. Follow-up should then be made with Form CA-3.

PAY RATE INFORMATION

- Employee's base pay in items 12a or 21a should not include value of subsistence, quarters or other pay. These should be shown separately in their own columns.

PART - B

CONTINUATION OF PAY

- In most traumatic injury cases, the employee will have qualified for and received continuation of pay under 5 USC 8118 (FECA). When this occurs, items 9, 13, and 15 in Part A will usually be left blank. When there is a continuation of pay, Part B must always be completed, unless the information has been submitted on Form CA-7, Claim for Compensation on Account of Traumatic Injury.

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