Florida Trail Association
VOLUNTEER INJURY INSTRUCTIONS

Crew leaders should be familiar with the contents of this packet, carry it on each outing, and ensure that Trailhead Communication and Emergency Action Plans are in place before trail work begins.

IF AN INJURY OCCURS, FOLLOW THESE STEPS:

1. First Aid Lead initiates care for the patient. Get patient's medical and emergency contact information from Crew Leader. Write medical or SOAP notes if needed.

2. Communications Lead uses Trailhead Communication Plan (TCP) and calls 911 or relevant dispatch (if warranted). Relay pertinent medical or SOAP notes written by the First Aid Lead.

3. If immediate medical care is needed: Get emergency treatment by a medical provider.

4. Report injury to the US Forest Service and FTA. **In non-emergency situations, this notification occurs before formal medical care is sought. All injuries should be reported within 24 hours.**
   - USFS Administrator, Shawn Thomas: (850) 348-2780 (mobile)
   - FTA Trail Program Director, (352) 378-8823 x107

5. If needed, evacuate patient and send following documents with patient: medical and emergency contact information, SOAP note, TCP. Transportation can be provided by any member of the crew, FTA staff or agency partner.
   - The patient may use, and FTA encourages, any insurance they have available as a private citizen.
   - Private insurance cannot be used in combination with federal workers' compensation.
   - Once private insurance is used, the patient cannot switch to federal workers' compensation.
   - Once federal worker's compensation has been used, the patient cannot switch to private insurance.
   - If the patient chooses to use federal workers' compensation coverage, their medical provider must be enrolled as an OWCP FECA provider. All emergency rooms are OWCP FECA providers.
   - **More information about federal workers' compensation on Page 2.**

6. Contact the patient's emergency contact.

SUBMIT ALL DOCUMENTATION TO USFS AND FTA AS SOON AS POSSIBLE:

1. Patient should complete Form CA-16 (Authorization for Examination and/or Treatment), **even if medical treatment is not sought.**

2. Completed Witness Statements.

3. Additional documentation is required if patient uses federal workers' compensation coverage for medical treatment. See Page 2.

THIS PACKET INCLUDES:

1. Volunteer Injury Instructions
2. Witness Statement: 2 copies
3. Saw Related Incident Report
4. Form CA-16 Authorization for Examination and/or Treatment: 2 copies
5. SOAP Notes

For additional copies of this packet, download forms from www.floridatrail.org/crew-leader-corner/ or contact FTA at 352-378-8823.

ADDTIONAL INFORMATION FOR FEDERAL WORKERS' COMPENSATION:

A volunteer working on the Florida National Scenic Trail is officially a volunteer of the U.S. Forest Service (USFS) and is entitled to certain protections when safety requirements and current volunteer agreements are in place.

The FTA Assumption of Risk Form and appropriate Job Hazard Analyses (JHAs) must be reviewed and signed **prior** to the beginning of the work trip and after the project should be sent to the FTA at 1022 NW 2nd St Gainesville, FL 32601.

Volunteers must work within the scope of their volunteer agreement, which includes following basic safety practices. This includes participating in a daily pre-work safety briefing (tailgate safety session), using all required personal protective equipment (PPE), and obtaining required training and certifications for specific tasks (example: chain saw or crosscut saw operation).

Volunteers are not covered if injured during the drive between home and the volunteer project site. Volunteers are covered if injured when transporting between the tailgate safety session location and the starting location of trail work. Volunteers are not compensated for time lost on a paid job due to an injury suffered as a volunteer.

STEPS FOR FEDERAL WORKERS' COMPENSATION:

1. In non-emergency situations and for ongoing treatment, the patient must confirm that their preferred medical provider is enrolled as an OWCP FECA provider (Office of Workers' Compensation Programs, Federal Employee's Compensation Act). Visit OWCP's online portal (https://owcpmed.dol.gov/ecams/PortalServlet) to search providers. FTA staff can assist in finding an enrolled provider. If the patient does not verify that the medical facility is enrolled, they could be liable for payment.

2. If emergency medical treatment is needed, inform the medical facility that the patient has been injured as a volunteer for the US Forest Service and will be pursuing federal workers' compensation.

   If the medical facility has concerns, they can contact the U.S. Department of Labor, OWCP in Albuquerque, N.M., for additional information and emergency authorization. During regular business hours, call OWCP at (877) 372-7248, option 2, then option 5.

3. USFS submits and certifies the incident and supporting documents in eSafety to file the claim.

4. The patient will receive an email once the Department of Labor has assigned a claim number. The patient may also retrieve claim number by calling OWCP at (877) 372-7248.

5. It is the patient's responsibility to provide the DOL claim number to all medical providers for billing. Failure to do so may result in bills being sent to collections. If bills go into collections, OWCP cannot reverse the process.

Questions or concerns?
Contact FTA's Trail Program Director, at (352) 378-8823 x107 or incident@floridatrail.org

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?

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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 [ ] Seasonal Employee [ ] Permanent Employee [ ]
Timber [ ] Fire [ ] Recreation [ ] Engineering [ ] LEI [ ]

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 [ ] eye protection [ ] ear protection [ ] long-sleeved shirt [ ] gloves [ ] long pants [ ] chaps [ ] 8" leather boots [ ]
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 [ ] MTDC [ ] Game of Logging [ ] 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.

Authorization for Examination And/Or Treatment

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

The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. 130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. NOTE: THIS FORM IS NOT TO BE REPRODUCED OR DUPLICATED (See Instructions). IF INSTRUCTIONS ARE SEPARATED FROM THIS FORM, REFER TO FORM INFORMATION https://www.dol/owcp/dfec

OMB No.: 1240-0046
Expires: 03-31-2021

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service within the meaning of FECA (See Instructions for definition of a qualified physician):

2. Employee's Identification (last, first, middle, SSN)	3. Date of Injury (mo. day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services. PLEASE NOTE THIS AUTHORIZATION DOES NOT INCLUDE PRESCRIPTIONS FOR COMPOUND MEDICATIONS. SEE INSTRUCTIONS FOR ADDITIONAL MEDICAL INFORMATION.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from (Type Name and Title of OWCP Official)

8. Name and Address of Employee's Place of Employment

Department or Agency:

Bureau or Office:

Local Address (Including Zip Code)

9. Local Employing Agency Telephone Number (Including Area Code):

10. Name and Title of Authorized Official (Type or Print Clearly): (See Instructions)

11. Send one copy of your report to:

U.S. DEPARTMENT OF LABOR
DFEC CENTRAL MAILROOM
P.O. BOX 8300
LONDON, KY 40742-8300

12. I certify that I am the individual authorized by my employing agency to issue this form concerning medical treatment. I further certify that the information provided above is true and accurate to the best of my knowledge and belief. I realize that any person who knowingly makes any false statement or misrepresentation to obtain FECA compensation is subject to civil or administrative remedies as well as criminal prosecution.

Signature of Authorizing Official/Date (Month, Day/Year)

13. Remarks (See Instructions under Authorized Official):

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.

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

15. What History of the Employment Injury or Disease Did The Employee Give To You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. ICD Code(s)

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is the Diagnosed Condition(s)

18a. ICD Code(s)

19. Do You believe the Condition(s) Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) ☐ Yes ☐ No

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee Is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. I certify that all the statements in this form are true and accurate to the best of my knowledge and belief. Further, I understand that 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, including payment for medical treatment or supplies, 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, and that physicians are subject to criminal and civil prosecution. In addition, a state or federal criminal conviction for FECA fraud will result in a beneficiary's termination of all current and future FECA benefits.

Print/Typed Name/Signature of Physician (See Instructions for Definition)

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

PAYMENT/MEDICAL BILLING: This CA-16 guarantees payment to the original treating physician (or any physician to whom the employee was referred by the original treating physician) for 60 days from date of issuance unless OWCP terminates this authority at an earlier date. Treatment may continue at OWCP expense if the claim is approved. Charges for your services should be presented on the AMA standard "Health Insurance Claim Form" (HCFA-1500, OWCP-1500, OWCP-04 or the UB-04). Physician services must be itemized by Current Procedural Terminology Code (CPT) using current CPT-4 coding schema; or, the UB-04 and the coding schemas acceptable on this form.

Authorization for Examination And/Or Treatment

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

The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. 130. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. NOTE: THIS FORM IS NOT TO BE REPRODUCED OR DUPLICATED (See Instructions). IF INSTRUCTIONS ARE SEPARATED FROM THIS FORM, REFER TO FORM INFORMATION https://www.dol/owcp/dfec

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5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services. PLEASE NOTE THIS AUTHORIZATION DOES NOT INCLUDE PRESCRIPTIONS FOR COMPOUND MEDICATIONS. SEE INSTRUCTIONS FOR ADDITIONAL MEDICAL INFORMATION.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from (Type Name and Title of OWCP Official)

8. Name and Address of Employee's Place of Employment

Department or Agency:

Bureau or Office:

Local Address (Including Zip Code)

9. Local Employing Agency Telephone Number (Including Area Code):

10. Name and Title of Authorized Official (Type or Print Clearly): (See Instructions)

11. Send one copy of your report to:

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P.O. BOX 8300
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12. I certify that I am the individual authorized by my employing agency to issue this form concerning medical treatment. I further certify that the information provided above is true and accurate to the best of my knowledge and belief. I realize that any person who knowingly makes any false statement or misrepresentation to obtain FECA compensation is subject to civil or administrative remedies as well as criminal prosecution.

Signature of Authorizing Official/Date (Month, Day/Year)

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PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

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16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
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16a. ICD Code(s)

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is the Diagnosed Condition(s)

18a. ICD Code(s)

19. Do You believe the Condition(s) Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) ☐ Yes ☐ No

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee Is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. I certify that all the statements in this form are true and accurate to the best of my knowledge and belief. Further, I understand that 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, including payment for medical treatment or supplies, 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, and that physicians are subject to criminal and civil prosecution. In addition, a state or federal criminal conviction for FECA fraud will result in a beneficiary's termination of all current and future FECA benefits.

Print/Typed Name/Signature of Physician (See Instructions for Definition)

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

PAYMENT/MEDICAL BILLING: This CA-16 guarantees payment to the original treating physician (or any physician to whom the employee was referred by the original treating physician) for 60 days from date of issuance unless OWCP terminates this authority at an earlier date. Treatment may continue at OWCP expense if the claim is approved. Charges for your services should be presented on the AMA standard "Health Insurance Claim Form" (HCFA-1500, OWCP-1500, OWCP-04 or the UB-04). Physician services must be itemized by Current Procedural Terminology Code (CPT) using current CPT-4 coding schema; or, the UB-04 and the coding schemas acceptable on this form.

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A. PLEASE READ FIRST. The CA-16 is solely used by the employing agency to authorize emergency care to an injured employee. To protect against potential fraud and abuse, it is important that this form not be duplicated or reproduced **without express written consent by OWCP** to include via **electronic means (including Internet postings). PLEASE ENSURE THESE INSTRUCTIONS ACCOMPANY THE CA-16 FORM.**

AUTHORIZING OFFICIAL

- Authorized personnel may include an Injury Compensation Specialist, Safety Specialist, or Human Resources Specialist whose current position includes duties relate to the FECA program. The injured employee's Supervisor or other individual in their supervisory chain of command at the time of injury may also sign and issue this form. If you are other than these noted, please explain in the Remarks section, item 13 of the CA-16 the circumstances which required issuance by you and to what authority, if applicable. Please be aware that union officials, claimant representatives, or others may not serve as an authorizing official unless they meet the criteria listed above.

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical office or hospital or any duly qualified physician/ hospital of the employee's choice.

- If an employee elects to be treated by a private physician; a copy of the American Medical Association Standard Billing Form (AMA) OWCP-1500 should be supplied together with the submitted Form CA-16. Additionally, medical providers should register with the OWCP Medical Bill Processing Contractor in order to receive payment. Further information can be found on the DFEC website at https://www.dol.gov/owcp/dfec/

- If an employee, in an emergency situation has to be sent and/or admitted to an Acute Care Facility for emergency surgery or care, a copy of the OWCP Uniformed Billing Form (UB-04-1450) should be supplied together with the submitted Form CA-16.

- A physician who is excluded from the FECA program as provided at 20 CFR 10.815-826 may not be authorized to examine or treat an injured Federal employee.

- Generally, a roundtrip distance of up to 100 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered. For non-emergency medical treatment, if roundtrip travel of more than 100 miles is contemplated, or air transportation or overnight accommodations will be needed, submit a written request to OWCP for prior authorization with information describing the circumstances and necessity for such travel expenses.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of injury, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U. S. Medical Facilities include Army, Navy, Air Force or the VA. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.300).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP. Simple exposure to a workplace hazard, such as an infectious agent, does not constitute a work place injury, entitling an employee to medical treatment under FECA.

QUALIFIED MEDICAL FACILITY/ PHYSICIAN

- *Qualified hospital* means any hospital licensed as such under State law which has not been excluded by the FECA program in accordance with its governing regulations. Except as otherwise provided by regulation, a qualified hospital shall be deemed to be designated or approved by OWCP.

- *Qualified provider of medical support services or supplies* means any person, other than a physician or a hospital, who provides services, drugs, supplies and appliances for which OWCP makes payment who possesses any applicable licenses required under State law, and who has not been excluded.

- The term "physician" includes doctors of medicine (MDs), surgeons, podiatrists, dentists, clinical

psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination related laboratory test and X-rays to diagnose a subluxation of the spine and treatment consistent of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

- Qualified physician means any physician who has not been excluded under the provisions of subpart I of this part. Except as otherwise provided by regulation, a qualified physician shall be deemed to be designated or approved by OWCP. (See 20 CFR. 10.5, WHAT DEFINITIONS APPLY TO REGULATIONS IN THIS SUBCHAPTER)

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 in Item 6, whichever is appropriate.

FORM COMPLETION

- Send the completed form to the OWCP address shown in item 11. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Publication CA-810, Injury Compensation for Federal Employees.

REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES

- If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

Patient Assessment

Patient Name: Date: Time:

Airway

Breathing

Circulation

Disability

Environment

Focused Exam

- Head/Neck
- Shoulders/Clavicle
- Chest/Sternum
- Abdomen
- Pelvis/Hips
- Legs/Feet
- Arms/Hands
- Back Cervical Thoracic Lumbar Sacrum Coccyx

Get Vitals

- Time
- Level of Responsiveness (AVPU)
- Heart Rate/Rhythm/Quality
- Respiration Rate/Rhythm/Quality
- Skin Color/Temp/Moisture

History

- 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)

Objective

(Patient Exam SAMPLE History)

Vital Signs

Time	AVPU	HR/Character	RR/Character	SCTM

Assessment

Plan

Rescue Request

Location	Quadrangle/Coordinates Area Description
On The Scene Plans	Stay Put Evacuate to trail to road to local shelter Will send some members out Notes:
Equipment Needed	Food Water Shelter Stove and Fuel Sleeping Bags Climbing Hardware Rope Notes:
Weather	Temp: Hot Warm Cold Freezing Precip: Dry Intermittent Rain Rain Snow Notes:
Type of Evacuation	Lowering Operating Carry Out Rigid Stretcher Helicopter None until specialized medical assistance Notes:
Remaining Party Members	Name Notify Phone
Notes	

Cut Here

Cut Here

Vital Sign Record

Time	Heart Rate		Respiratory Rate		Skin	LOR	BP
Date Hour	Beats Per Minute	Character: Strong Weak Regular Irregular	Breaths Per Minute	Character: Deep Shallow Noisy Labored	Color Temperature Moisture	AVPU	Blood Pressure

Focused Spine Exam: Date_____ Time_____ Patient Assessment/History Complete_____

Reliable (A+0x3, Sober, No Distract Injury)_____ CSM (4 Extremities)_____ No Spine Tenderness_____

DBB 11/01/07