MEMORANDUM

U.S. Department
of Transportation

**Federal Aviation
Administration**

FAA AEROSPACE MEDICINE DIVISION – ZMA-300

**7500 NW 58th Street
Miami, Florida 33166
Tel – 305-716-1300
Fax –305-716/1624**

AIR TRAFFIC CONTROLLER HEALTH PROGRAM

*** PSYCHOLOGICAL/PSYCHIATRIC DISORDER STATUS REPORT ***

Air traffic controllers who have disqualifying psychological or psychiatric condition(s) *must have their attending* ***PSYCHIATRIST/PSYCHOLOGIST*** *provide the following medical information in order that the appropriate medical certification determination may be made.* ***This report is due by: AS PER TREATING PHYSICIAN .***

Case: 062270339

NAME *Kristin M. Noe* **FACILITY** *Miami ARTCC*

Current Subjective Status: (Symptoms/subjective complaints) *Pt suffers from acute anxiety disorder current in* full remission.

Current Objective Status: ***(Results of current evaluation; attach results of any tests/procedures to this form)***
Pt currently in remission.

Diagnosis:

TREATMENT: Cognitive behavioral psychotherapy.

Medications: ***none*** *Dosage* *Start date* *Discontinued Date*

Response to treatment and duration Pt responds well to brief cognitive behavioral psychotherapy

SIDE EFFECTS OF MEDICATION(S) EXPERIENCED BY PATIENT: – DO NOT LEAVE BLANK

☒ None ☐ AS FOLLOWS (especially note any sedation or impairment of intellectual functioning)
none

CURRENT FUNCTIONAL IMPAIRMENT: (from illness or medication) - **DO NOT LEAVE BLANK**

☒ NONE ☐ AS FOLLOWS (especially note any sedation or impairment of intellectual functioning)
Pt currently in remission.

PROGNOSIS: Pt has good prognosis for return to work with no restrictions.

Estimated date of return to Air Traffic Control duties: February 10, 2011

WORK LIMITATIONS – DO NOT LEAVE BLANK

HAS CONDITION BEEN RESOLVED? ☒ **YES** ☐ **NO** **STABLE** **Yes** **FOLLOW UP** **No**

Signature of physician William M. Beecham, Ph.D. **Date** February 9, 2011

Print or type physician's name: **William M. Beecham, PH.D.**

Address: 2499 Glades Road Suite 302, Boca Raton Fl 33431

Telephone: 561.393.0360 **Fax:** 561.391.9628

DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION

PERSONNEL STATEMENT

1. NAME OF REPORTING FACILITY:	2. REPORT NUMBER:

3. AIRCRAFT IDENTIFICATION AND TYPE: DAL1564 A319 PGF4960 AT72

4. LOCATION OF ACCIDENT/INCIDENT:	5. DATE/TIME OF ACCIDENT/INCIDENT (UTC):	6. EQUIPMENT ATTACHMENT:
Anney	2255 Jan 22, 2011	☐ YES ☐ NO

7. NAME (OPERATING INITIALS):	8. TITLE:	9. POSITION AND TIME (UTC):
Kristin NOF KB	ATCS	D20 2208-2255

10. COMPLETE IN ACCORDANCE WITH FAA ORDER 8020.16, AIR TRAFFIC ORGANIZATION, AIRCRAFT ACCIDENT AND INCIDENT NOTIFICATION, INVESTIGATION, AND REPORTING, PARAGRAPH 91, FAA FORM 8020-26, PERSONNEL STATEMENTS. THE PURPOSE OF THIS STATEMENT IS TO PROVIDE ANY FACTS WITHIN YOUR PERSONAL KNOWLEDGE THAT WILL PROVIDE A COMPLETE UNDERSTANDING OF THE CIRCUMSTANCES SURROUNDING THIS ACCIDENT/ INCIDENT. SPECULATIONS, HEARSAY, OPINIONS, CONCLUSIONS, AND/OR OTHER EXTRANEOUS DATA ARE NOT TO BE INCLUDED IN THIS STATEMENT. THIS STATEMENT MAY BE RELEASED TO THE PUBLIC THROUGH THE FREEDOM OF INFORMATION ACT OR LITIGATION ACTIVITIES INCLUDING PRETRIAL DISCOVERY, DEPOSITIONS, AND ACTUAL COURT TESTIMONY. THIS STATEMENT IS TO BE HAND PRINTED AND SIGNED BY YOU, AND YOUR SIGNATURE BELOW CERTIFIES THE ACCURACY OF THIS STATEMENT. IT WILL NEITHER BE EDITED NOR TYPED AND, ONCE SIGNED, WILL CONSTITUTE YOUR ORIGINAL STATEMENT.

11. TEXT OF STATEMENT: ☐ ORIGINAL ☐ SUPPLEMENTAL

I was listening to the R20 controller switch DAL1564 to MIA approach. DAL1564 never acknowledge the communications switch. The R20 controller moved on to other aircraft. The R20 controller came back to DAL1564 but called him AAL1564. R20 controller then called the aircraft DAL1564 to see if he was still monitoring the frequency but there was no response. The R20 controller then gave JBU569 a descent to 8000 but DAL1564 took the clearance. Approach then called looking for DAL1564 and we tried switching him again.

12. SIGNATURE OF WITNESS:	13. DATE OF SIGNATURE:
Kristin Noe	1/22/11

FAA Form 8020-26 (08-05)

File Number: 062270339
nodfoi-factual (stress)-D-I

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300
Phone: (904) 357-4777

March 10, 2011

Date of Injury: 01/22/2011
Employee: KRISTIN M. NOE

KRISTIN M NOE
1626 NW 143RD WAY
PEMBROKE PINES, FL 33028

Dear Ms. NOE:

NOTICE OF DECISION

Your claim for compensation is denied as the evidence is not sufficient to establish that you sustained an injury as defined by the Federal Employees' Compensation Act (FECA).

On 01/23/2011, you filed a claim for Traumatic Injury indicating you sustained an emotional condition as a result of your employment as an Air Traffic Control Specialist with the Department of Transportation in Miami, FL. Specifically, you stated that your emotional condition occurred due to an operational error in your air traffic control duties.

Along with your claim, you submitted a medical report dated 1/27/11.

The evidence submitted was insufficient to establish your claim because the injury, accident or employment factor alleged must have actually occurred.

On 02/08/2011, this office advised you of the deficiencies in your claim and provided you the opportunity to submit additional evidence. Specifically, you were asked to submit a written statement and to describe in detail the employment related condition(s) or incident(s) which you believe contributed to your illness. Your agency was also asked to provide a written statement concerning these conditions and incidents. You were provided 30 days to submit the requested information.

In response to our development letters, we received the following evidence:

Medical reports dated 2/2/11, 2/5/11, 2/7/11, and 2/9/11
Attending physician's report dated 2/9/11
Your written statement dated 2/18/11
Agency written statements dated 2/9/11 and 2/16/11

In order for a claim to be accepted under the Federal Employees' Compensation Act (FECA), the claim must meet 5 basic elements. The claim must:

(1) Be Timely Filed.
(2) Be made by a Federal Civil Employee.
(3) Establish Fact of Injury, which has both a factual and medical component. Factually, employment incident(s) alleged must have actually occurred. Medically, a medical condition must be diagnosed in connection with the specified employment incident.

(4) Establish Performance of Duty. The medical condition must have arisen during the course of employment and within the scope of compensable work factors.
(5) Establish Causal Relationship, which means the medical evidence establishes that the diagnosed condition is causally related to the accepted employment factors.

You have established that you are a Federal civilian employee who filed a timely claim; however, after a thorough review of all evidence, your claim is denied because the factual component of the third basic element, Fact of Injury, has not been met. Under the Federal Employee's Compensation Act, you must establish a factual basis to support your claim and the evidence does not support that you actually experienced the employment incident(s) alleged to have occurred.

You alleged the following incident: You were involved in an operational error; an aircraft under your control came within close proximity of another aircraft.

The office finds that the alleged incident did not occur because your agency has provided evidence that you were not actually responsible for the control of the aircraft and that although the proximity of the aircraft to other aircraft in a terminal radar environment was not within standards there was no danger to the aircraft or its' passengers. Your agency, in a written statement dated 2/16/11, indicates that at the time of the alleged incident that you were not responsible but were assisting the air radar controller who was responsible for the involved aircraft. Also your agency has provided information that the separation from other aircraft was 2.68 nautical miles lateral and 0 feet vertical or 2.5 nautical miles lateral and 500 feet vertical depending upon the measurement reference. Although the separation standard is 1000 feet vertically or 3 nautical miles laterally the aircraft and its' passengers were not in danger as they made their approach for landing.

Based on these findings, your claim is denied on the factual component of the third basic element, Fact of Injury, because the evidence does not support that the injury and/or events occurred. The requirements have not been met for establishing that you sustained an injury as defined by the FECA. Medical treatment is not authorized and prior authorization, if any, is terminated.

Your employing agency will charge any previously paid Continuation of Pay to your sick and/or annual leave balance or declare it an overpayment.

If you disagree with this decision, you should carefully review the attached appeal rights and pursue whichever avenue is appropriate to your situation.

Sincerely,

Stephen Cory
Claims Examiner

Enclosure: Appeal Rights

DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION
WORKERS' COMP DIV-AHL-100
800 INDEP AVE, SW, RM 521,(AHP-500)
WASHINGTON, DC 20591

Case Number: 062270339
Employee: KRISTIN M. NOE
Date: March 10, 2011

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with the attached decision, you have the right to request an appeal. If you wish to request an appeal, you should review these appeal rights carefully and decide which appeal to request. There are 3 different types of appeal: HEARING (this includes either an Oral Hearing, or a Review of the Written Record), RECONSIDERATION, and ECAB REVIEW. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME.

Place an "X" on the attached form indicating which appeal you are requesting. Complete the information requested at the bottom of the form. Place the form on top of any material you are submitting. Then mail the form with attachments to the address listed for the type of appeal that you select. Always write the type of appeal you are requesting on the outside of the envelope ("HEARING REQUEST", "RECONSIDERATION REQUEST", or "ECAB REVIEW"). Your appeal rights are as follows:

1. HEARING: If your injury occurred on or after July 4, 1966, and you have not requested reconsideration, as described below, you may request a **Hearing**. To protect your right to a hearing, any request for a hearing must be made before any request for reconsideration by the District Office (5 U.S.C. 8124(b)(1)). **Any hearing request must also be made in writing, within 30 calendar days after the date of this decision, as determined by the postmark of your letter.** (20 C.F.R. 10.616). There are two forms of hearing. You may request either one or the other, but not both.
a. One form of Hearing is an **Oral Hearing.** An informal oral hearing is conducted by a hearing representative at a location near your home or by teleconference/videoconference. You may present oral testimony and written evidence in support of your claim. Any person authorized by you in writing may represent you at an oral hearing. At the discretion of the hearing representative, an oral hearing may be conducted by teleconference or videoconference.
b. The other form of a Hearing is a **Review of the Written Record.** This is also conducted by a hearing representative. You may submit additional written evidence, which must be sent with your request for review. You will not be asked to attend or give oral testimony.

2. RECONSIDERATION: If you have additional evidence or legal argument that you believe will establish your claim, you may request, in writing, that OWCP reconsider this decision. **The request must be made within one calendar year of the date of the decision**, clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted. This evidence might include medical reports, sworn statements, or a legal argument not previously made, which apply directly to the issue addressed by this decision. In order to ensure that you receive an independent evaluation of the new evidence, persons other than those who made this determination will reconsider your case. (20 C.F.R. 10.605-610)

3. REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB): If you believe that all available evidence that would establish your claim has already been submitted, you have the right to request review by the ECAB (20 C.F.R. 10.625). The ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). Effective November 19, 2008, ECAB has changed its Rules of Procedure on the time limit to appeal and has eliminated its practice of allowing one year to file an appeal. **Request for review by the ECAB must be made within 180 days from the date of this decision.** More information on the new Rules is available at www.dol.gov/ecab.

If you request reconsideration or a hearing (either oral or review of the written record), OWCP will issue a decision that includes your right to further administrative review of that decision.

Case Number: 062270339
Employee: KRISTIN M. NOE
Date: March 10, 2011

APPEAL REQUEST FORM

If you decide to appeal this decision, read these instructions carefully. You must specify which procedure you request by checking one of the options listed below. Place this form on top of any materials you submit. **Be sure to mail this form, along with any additional materials, to the appropriate address. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME.**

_____ **ORAL HEARING**

Depending on your geographical location, the issue involved in your case, the number of hearing requests in your area, and at the discretion of the hearing representative, we may expedite your appeal by providing you a telephone hearing or videoconference. **Please check here if you would prefer a telephone hearing.** _____

_____ **REVIEW OF THE WRITTEN RECORD**

For each of these options, you must submit this form within 30 calendar days of the date of the decision. You may also submit additional written evidence with your request. **You must mail your request to:**

Branch of Hearings and Review
Office of Workers' Compensation Programs
P. O. Box 37117
Washington, DC 20013-7117

_____ **RECONSIDERATION:**

Submit your request within 1 calendar year of the date of the decision. You must state the grounds upon which reconsideration is being requested. Your request must also include relevant new evidence or legal argument not previously made. **Mail your request to:**

DOL DFEC Central Mailroom
P. O. Box 8300
London, KY 40742

_____ **ECAB APPEAL:**

Submit this form within 180 calendar days of the date of the decision. No additional evidence after the date of OWCP's decision will be reviewed. To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on the Department of Labor Web Site at www.dol.gov/ecab. **You must mail your request to:**

Employees' Compensation Appeals Board
200 Constitution Avenue NW, Room S-5220
Washington, DC 20210

SIGNATURE_____TODAY'S DATE_____
PRINTED NAME_____DECISION DATE_____
ADDRESS_____PHONE_____
CITY _____STATE_____ZIP_____

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Reset Print

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

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): NOE | Kristin | Marie
2. Social Security Number: 247-61-2237
3. Date of birth (Mo. Day Yr.): 6/30/1984
4. Sex: Male ☐ Female ☑
5. Home telephone: 954-404-9649
6. Grade as of date of injury: Level ☐ Step ☐
7. Employee's home mailing address (include street address, city, state, and ZIP code): 1626 NW 143rd Way
   City: Pembroke Pines | State: FL | ZIP Code: 33028
8. Dependents: Wife, (Husband) Children under 18 years Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): 7550 NW 58th St, Miami, FL 33166 Miami ARTCC Control Room-Positran D20
10. Date injury occurred (Mo. Day Yr.): 1/22/11
    Time: 6:00 ☐ a.m. ☒ p.m.
11. Date of this notice (Mo. Day Yr.): 1/23/11
12. Employee's occupation: Air traffic Controller
13. Cause of injury (Describe what happened and why): I was working positran. I was involved in an operational error. An aircraft under my control came within close proximity of another aircraft. While this is not my fault I was responsible.
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg): Experiencing headaches and nervousness along with upset stomach.

a. Occupation code:
b. Type code:
c. Source code:
OWCP Use - NOI Code:

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☑ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Kristin Noe **Date** 1/23/11

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 felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury): I WAS WITH KRISTIN AFTER THE ERROR SHE WAS CLEARLY SHAKEN AND UPSET. SHE WAS VERY TEARY EYED AND NERVOUS.

Name of witness: ARIEL BERMAN | Signature of witness: [signature] | Date signed: 1/23/11

Address: 4460 NE 26th AVE | City: LIGHTHOUSE POINT | State: FL | ZIP Code: 33064

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include street address, city, state, and ZIP code): Federal Aviation Administration / National Headquarters
OWCP Agency Code:
800 Independence Ave S.W.
OSHA Site Code:
City: Washington State: DC ZIP Code: 20590

18. Employee's duty station (include street address, city, state, and ZIP code): Miami ARTCC / 7500 NW 58th Street City: Miami State: FL ZIP Code: 33166

19. Employee's retirement coverage: CSRS (FERS) Other, (identify):

20. Regular work hours From: 3:00 [ ] a.m. [X] p.m. To: 3:00 [ ] a.m. [X] p.m.

21. Regular work schedule: (Sun.) (Mon.) (Tues.) Wed. Thurs. (Fri.) (Sat.)

22. Date of Injury: 1/24/11

23. Date notice received: 1/25/11

24. Date stopped work: 1/25/11 Time: 7:00 [ ] a.m. [X] p.m.

25. Date pay stopped:

26. Date 45 day period began: 1/24/11

27. Date returned to work: Time: [ ] a.m. [ ] p.m.

28. Was employee injured in performance of duty? [X] Yes [ ] No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? [ ] Yes (If "Yes," explain) [X] No

30. Was injury caused by third party? [ ] Yes [X] No (If "No," go to item 32.)

31. Name and address of third party (include street address, city, state, and ZIP code)
City: State: ZIP Code:

32. Name and address of physician first providing medical care (include street address, city, state, ZIP code)
City: State: ZIP Code:

33. First date medical care received:

34. Do medical reports show employee is disabled for work? [ ] Yes [ ] No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? [X] Yes [ ] No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work: $ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print): ANDRE' A. FERGUSON
Signature of supervisor: Andre' A. Ferguson
Date: 11/23/11
Supervisor's Title: FRONT LINE MANAGER
Office phone: (305) 716-1783

39. Filing instructions
[ ] No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
[ ] No lost time, medical expense incurred or expected: forward this form to OWCP
[X] Lost time covered by leave, LWOP, or COP: forward this form to OWCP
[ ] First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third 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 whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason In detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury.

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee Is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN), and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee) KRISTIN NOE

Which occurred on (Mo., Day, Yr.) 01/22/11

At (Location)

MIAMI, AIR TRAFFIC ENROUTE

Signature of Official Superior

Title FRONT LINE MANAGER

Date (Mo., Day, Yr.) 01/23/11

*U.S. GPO: 1999-454-845/12704