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

Activity	Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day
b. Sitting	☐	☐	Hrs Per Day
c. Standing	☐	☐	Hrs Per Day
d. Walking	☐	☐	Hrs Per Day
e. Climbing	☐	☐	Hrs Per Day
f. Kneeling	☐	☐	Hrs Per Day
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l. Reaching above Shoulder	☐	☐	Hrs Per Day
m. Driving a Vehicle (Specify)	☐	☐	Hrs Per Day
n. Operating Machinery (Specify)	☐	☐	Hrs Per Day
o. Temp. Extremes	☐	☐	____ ____ range in degrees F
p. High Humidity	☐	☐	Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)	☐	☐	Hrs Per Day
r. Fumes/Dust (identify)	☐	☐	Hrs Per Day
s. Noise (Give dBA)	☐	☐	dBA Hrs Per Day

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)

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and send a copy of this report to the OWCP address noted below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

_____

_____

_____

Send Original Report to:

Employing Agency Address

_____

_____

_____

Send a Copy of this Report to:

Office of Workers' Compensation Programs
Division of Federal Employees', Longshore and Harbor Workers' Compensation
Federal Employees' Compensation Act
(OWCP/DFELHWC-FECA)
PO Box 8311
London, KY 40742-8311

Certification

By signing block 19 on the front of this form, the physician certifies as follows:

I certify that all the statements in response to the questions asked on this form ca-17 are true, complete and correct to the best of my knowledge. Further, i understand that any knowingly false or misleading statement, or misrepresentation or concealment of material fact, may subject me to criminal prosecution.

I further understand that this request does not constitute authorization for payment of medical expenses by the department of labor, nor does it invalidate any previous authorization issued in this case.

Notice

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.

Privacy Act Statement

In accordance with the Privacy Act of 1974, as amended (5 U.S.C.552a), you are here by 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 healthcare 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.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not send the completed form to this office.