File Number:
CA-1008 OD-D-ACC

U.S. DEPARTMENT OF LABOR

OWCP/DFEC, PO Box 8311
LONDON, KY 40742-8311
Phone: (904) 366-0100

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September 04, 2020

Date of Injury:
Employee:

Dear

This is to notify you that your claim for an occupational disease has been accepted for the following condition(s):

Diagnosed condition(s)	ICD-10 code(s)
POST-TRAUMATIC STRESS DISORDER, CHRONIC	F4312

Please advise all medical providers who are treating you for this injury of the accepted ICD-10 code(s). Accurate coding facilitates timely bill processing.

If the current accepted condition(s) need to be revised or additional complications related to the current accepted condition(s) need to be added, your physician should explain in writing, with medical rationale, the relationship between any additional condition and the work injury or the current accepted condition(s) noted above.

If you lose time from work due to your work related condition, you may claim compensation using Form CA-7.

The evidence in your case file at this time indicates that you may not have returned to work in a full-time capacity. OWCP is not a retirement program and our primary goals are your medical recovery and return to full duty employment. We strive for an active team approach where OWCP, the employing agency, and the medical providers work collaboratively with you to facilitate medical recovery and sustainable return to work. Your case is currently being evaluated to determine what steps we can take to help you achieve these goals.

Please refer to the attachment entitled "Now That Your Claim Has Been Accepted" for important information pertaining to how to contact us, medical authorizations, payment of bills, and returning to work.

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

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Sincerely,

Division of Federal Employees' Compensation

Enclosure: NOW THAT YOUR CLAIM HAS BEEN ACCEPTED

PAUL H FELSER
ATTORNEY
7393 HODGSON MEMORIAL DR
SUITE 102
SAVANNAH, GA 31406

NOTICE TO EMPLOYING AGENCY:
If Form CA-7 claiming compensation for wage loss is filed, you are reminded that 20 C.F.R. §10.111(c) requires the submission of a CA-7 within 5 working days. Please fully complete any form submitted and provide contact information to avoid delay of payment.

Please send a copy of the position description (including physical requirements) for the job held on date of injury.

Please submit an update regarding this employee's work status.