File Number:
CA-181-D-S

U.S. DEPARTMENT OF LABOR

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

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July 28, 2020

Date of Injury:
Employee:

Dear

Under the schedule award provisions of the Federal Employees' Compensation Act (FECA) at 5 U.S.C. 8107, the Office of Workers' Compensation Programs makes the following:

AWARD OF COMPENSATION

1. Degree and Nature of Permanent Impairment: 12% of the Left Arm and 12% of the Right Arm
2. Date of Maximum Medical Improvement:
3. Period of Award: to
4. Number of Weeks of Compensation: 37.44
5. Weekly Pay: $1815.10 X Compensation Rate: 75 % = $1361.33
6. Effective Date of Pay Rate:
7. After Cost-of-Living Adjustments, Your Weekly Compensation is: $NA
8. Your Payment and the Period Covered: $31,913.36 from to
9. Your Continuing Payment each Four Weeks: $5670.00

Payment of your award ends when you have been paid for the last day shown in item 3 above.

Section 8107 of the FECA and its implementing regulations set forth the number of weeks of compensation to be paid for the permanent loss or loss of use of specified members, functions and organs of the body known as permanent impairment. 20 C.F.R. 10.404; see also 20 C.F.R. Part 10. The commencement period of the schedule award is usually the date of maximum medical improvement, the date that the physical condition of the injured member has stabilized and is not expected to improve further.

The FECA, however, does not in most instances specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. The implementing regulations have adopted the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, as the appropriate standard for evaluating schedule losses. Currently, schedule awards are calculated using the Sixth Edition of the AMA *Guides*.

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.

The percentage of permanent impairment noted above was based on the medical findings and report of Dr. dated and the report of the District Medical Advisor (DMA) dated Copies of these reports are provided for your reference.

The percentage of impairment shown above was calculated by a District Medical Advisor, who applied the Guides to the medical findings provided by your treating physician and determined the date of maximum medical improvement based on the medical evidence of record. The impairment percentage above differs from the percentage provided by your treating physician. In reviewing the evidence, the District Medical Advisor has determined that your physician incorrectly applied the Guides to the findings on examination. A copy of the District Medical Advisor's calculation, which explains this discrepancy, is attached. The weight of the medical evidence regarding the percentage of impairment is being given to the District Medical Advisor because he correctly applied the Guides to the examination findings.

IMPORTANT INFORMATION

Please read the following information carefully. Keep this award letter so you can refer to it when necessary. If you have questions concerning this award, write to the address shown in the letterhead.

1. HOW COMPENSATION IS PAID - Direct deposit is the fastest and most secure way to receive your award payments. **We strongly encourage you to submit a Standard Form 1199A, which will enable us to direct deposit your payment(s) into your bank.** Your first payment will be issued within 30 days. If further payments are due, they will be made every four weeks until the expiration of the award.

2. LUMP SUM PAYMENTS - If you are currently working, or if you are receiving retirement benefits from the Office of Personnel Management, you may be entitled to a "lump-sum" payment of your schedule award. Please contact the District Office at the address listed on the first page of this letter and specifically request information concerning this option.

3. CHANGE OF ADDRESS - Notify this office immediately of any change of address either for correspondence or for direct deposit. Notification must be in writing, signed by you, to the address shown on the first page of this letter. Include your file number, your old address, and your new address.

4. CHANGE IN STATUS OF DEPENDENTS - If your award is paid at the augmented rate of 3/4 because you have one or more dependents, you are required to provide written notification immediately of any change in status of your dependents, to the address on the first page of this letter. The notice must be signed by you and include your file number, the name of the dependent whose status changed, the effective date of the change, and the nature of the change in status. If you originally claimed only one dependent, and there is a change in the status of your sole dependent, do not cash any checks you receive after the change in status of that dependent. Return the checks promptly for adjustment by this Office.

5. RETURN TO WORK - You may work or receive retirement benefits from the Office of Personnel Management (OPM) during the period of this award without any effect on your schedule award payments.

6. SOCIAL SECURITY DISABILITY BENEFITS - Please contact your local Social Security Office regarding this award if you are receiving or have filed for Social Security Disability Benefits.

7. VA BENEFITS - You are required to notify this office if you have received, or are receiving any VA benefits for the same part of the body.

8. EXPIRATION OF AWARD – After the ending date of this award noted in item 3, your entitlement to compensation will be based solely on disability for work resulting from the accepted injury. You may claim continuing compensation by submitting evidence showing that the accepted injury prevents you from performing the kind of work you were doing when injured and from earning comparable wages. Please note that compensation for disability cannot be paid for any period during which you receive retirement benefits from OPM.

9. ATTORNEY AND REPRESENTATIVE FEES – Please be mindful of the following regarding fees for representative services:

- In each case where a representative's fee is desired, an application for approval of the fee must be submitted to OWCP.
- Fees collected prior to OWCP approval may constitute a misdemeanor under 18 U.S.C. § 292.
- Contingency fees are not allowed in any form. See 20 C.F.R. § 10.702 (a). Further, a fee will not be approved merely on the basis of a percentage of the amount of compensation awarded. All fees claimed for services rendered must be calculated on an hourly basis.
- The ultimate collection of the fee is a matter between the representative and the claimant.

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

Sincerely,

Claims Examiner
Division of Federal Employees' Compensation

Enclosures: Appeal Rights

PAUL FELSER
ESQ
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

Case Number:
Employee:
Date: July 28, 2020

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with the attached decision, you have the right to request an appeal. Review these appeal rights carefully and decide which appeal to request. There are 3 different types of appeal as outlined below. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT A 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. Follow the filing instructions (including the type of appeal) and be aware of the time constraints for each appeal.

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)). **A hearing request must be made in writing, within 30 calendar days of the date of this decision, as determined by the postmark of your letter.** (20 C.F.R. 10.616) or as received in ECOMP. There are two forms of hearings, both conducted by a hearing representative—**choose one**.

a. **Oral Hearing.** An informal oral hearing is conducted by teleconference unless otherwise determined. 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.

b. **Review of the Written Record.** You may submit additional written evidence/argument 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 signed, dated and received within one calendar year of the date of the decision.** It must clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted, such as medical reports or legal arguments which apply directly to the issue addressed by this decision. A person other than those who made this decision will reconsider your case. (20 C.F.R. 10.605-610)

3. REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB): You have the right to request review by ECAB (20 C.F.R. 10.625). ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). **Request for review by ECAB must be made directly to the Board within 180 days from the date of this decision.** To file your appeal with ECAB electronically please visit https://www.dol.gov/ecab/welcome.html. There, you can register with ECAB and file your notice of appeal immediately with the Board. Alternatively, you may submit an Application for Review (AB 1 form) by mail or fax to the Clerk of the Appellate Boards. The AB 1 form can be found here: https://www.dol.gov/ecab/ab-1.pdf.

If you have a disability, federal law gives you the right to receive communication assistance, accommodation(s) and/or modification(s) from DOL such as documents in alternate formats; communication services such as sign language interpretation; or other adjustments/changes to accommodate your disability.

Case Number:
Employee:
Date: July 28, 2020

APPEAL REQUEST FORM If you decide to appeal this decision, read these instructions carefully. You must specify which procedure you request and select **ONLY ONE** option listed below. Place this form on top of any materials you submit. **Submit this request, along with any additional materials electronically or to the appropriate address.**

1. **HEARING**

_____ **REVIEW OF THE WRITTEN RECORD or**

_____ **ORAL HEARING** Hearings will be conducted telephonically unless it is determined that it is necessary that a hearing be conducted in person or by videoconference. If you believe that you require a non-telephonic hearing, please explain below.

_____

_____

For each option above, you must submit this form within 30 calendar days of the date of the decision. You may submit additional written evidence/argument with your request. You may also electronically file your hearing request via ECOMP, an OWCP-hosted free web-based application. To upload and designate a hearing request, visit https://www.ecomp.dol.gov/#Upload_Documents If you are mailing a hearing request, do not mail this request to the District Office. **If mailing a hearing request, send to:**

Branch of Hearings and Review
Office of Workers' Compensation Programs
P.O. Box 8311
London, KY 40742-8311

2. **RECONSIDERATION BY THE DISTRICT OFFICE**

_____ **RECONSIDERATION:** Your request must be **signed, dated and received** by OWCP within **1 calendar year** of the decision date. You must state the grounds for reconsideration and include relevant new evidence and/or legal argument. You may electronically file your reconsideration request via ECOMP, an OWCP-hosted free web-based application. To upload and designate a reconsideration request, visit https://www.ecomp.dol.gov/#Upload_Documents . If mailing a reconsideration request, send to:

DOL DFEC Central Mailroom
P.O. Box 8311
London, KY 40742-8311

3. **REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD.**

_____ **ECAB APPEAL:** An ECAB appeal must be filed within **180 calendar** days of the date of this decision. New evidence may **not** be submitted on appeal and any additional evidence received after the date of OWCP's decision will not be reviewed. **Your ECAB appeal request must be made directly to ECAB and cannot be not mailed to the District Office or uploaded via ECOMP.** To file your appeal with ECAB electronically please visit https://www.dol.gov/ecab/welcome.html. You can register with ECAB and file your notice of appeal immediately with ECAB. Alternatively, you may submit an Application for Review (AB 1) https://www.dol.gov/ecab/ab-1.pdf by mail or fax. Information about filing an ECAB appeal can be found at https://www.dol.gov/ecab/appeal-info.htm If mailing an ECAB appeal request, send to: **ECAB Office of the Clerk, U.S Department of Labor, 200 Constitution Ave NW S5220, Washington, DC 20210.**

SIGNATURE_____TODAY'S DATE_____

PRINTED NAME_____DECISION DATE_____

ADDRESS_____

PHONE_____

PAUL FELSER
ESQ
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

Want Faster Service?
Upload Your Response or ANY Document at: ecomp.dol.gov