File Number:
CA-181-D-S

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U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300
Phone: (904) 366-0100

February 12, 2013

Date of Injury:
Employee:

Dear Ms. :

Per decision of the Branch of Hearings and Review, 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: additional 2% impairment left shoulder previously paid 9% = 11% total impairment
2. Date of Maximum Medical Improvement: 02/21/2012
3. Period of Award: 09/05/2012 to 10/18/2012
4. Number of Weeks of Compensation: 6.24
5. Weekly Pay: $817.54 X Compensation Rate: 66 2/3 % = $544.48
6. Effective Date of Pay Rate: 05/09/2011
7. After Cost-of-Living Adjustments, Your Weekly Compensation is: $544.48
8. Your Payment and the Period Covered: $3400.97 from 09/05/2012 to 10/18/2012.
9 Your Continuing Payment each Four Weeks: N/A

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 (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

The percentage of permanent impairment noted above was based on the medical findings and report of Dr. dated 12/15/2012 and the report of the District Medical Advisor (DMA) dated 01/24/2013 Copies of these reports are provided for your reference.

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.

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

Sincerely,

Nancy L. Chasse
Claims Examiner

Enclosures: Appeal Rights

PAUL FELSER
FELSER LAW FIRM, PC
PO BOX 10267
SAVANNAH, GA 31412

Case Number:
Employee:
Date: February 12, 2013

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 as outlined below. 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").

NOTE - If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from DFEC in the form of communication assistance, accommodation and modification to aid you in the FECA 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 account for the limitations of your disability. Please contact the appropriate office below to ask about this assistance.

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 hearings, both conducted by a hearing representative. You may request either one or the other, but not both.

a. **Oral Hearing.** An informal oral hearing is conducted 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 **Review of the Written Record.** 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 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, sworn statements, or a legal argument not previously made, 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): 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). **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.

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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. Do not mail this appeal request to the District Office. **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:

Your request must be signed, dated and received by OWCP 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. Do not mail this appeal request to the District Office **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_____