

Covid claim filing in ECOMP

How to file a CA-1 for a positive Covid-19 diagnosis

Covid – 19 Claims

Log in or register in ECOMP here:

<https://www.ecomp.dol.gov/#/>

Or scan this QR code to go
directly to ECOMP registration



You must have a positive PCR test to file a claim

You must have worked within 21 days prior to when you took your positive test

Once you are logged in choose FILE CA-1 FOR COVID-1

Choose your District

Indiana: 460-479

KY - WV: 247-268, 400-418, 420-427

Michigan 1: 480-485, 492

Michigan 2: 486-491, 493-499

ecomp.dol.gov

EMPLOYMENT STATUS [?](#)

Federal Employee Contractor

GOVERNMENT ORGANIZATION [?](#)

What part of the government were you working for at the time of your injury?

Select Department

UNITED STATES POSTAL SERVICE [▼](#)

Agency Group
SOUTHERN AREA

Agency
PUERTO RICO

Duty Station
OCCUPATIONAL HEALTH CLAIMS OFFICE, 585 F D ROOSEVELT AVE STE 201, SAN JUAN, PR 00936

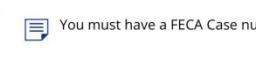
You can file forms CA-1, CA-2, CA-3, CA-6, CA-7, CA-7a, CA-16 for this organization through ECOMP [?](#)

To file a form for injury or illness:

1 Claim benefits using either form **CA-1 (for Traumatic Injury)** or form **CA-2 (for Occupational Disease)**. Pending review of your claim, you may receive a FECA Case Number. If you are filling a claim for COVID-19, use FORM CA-1 COVID-19. (FORM CA-1 COVID-19 should not be used for a claim related to a COVID-19 vaccination.) [?](#)

FILE CA-1 OR CA-2 FILE CA-1 COVID-19 

2 If you wish to claim compensation and you've received an official FECA Case Number, you can file form **CA-7 (Claim for Compensation)**.

FILE CA-7  You must have a FECA Case number to file a CA-7

Personal Information

Grade and step can be found on your paystub

Newly hired CCAs are Grade 1 Step BB

After first break in service CCAs are step AA

The screenshot shows a web-based application interface for selecting dependents and specifying who should review the form. At the top, there is a header bar with a back arrow, forward arrow, and other standard browser controls. Below the header, the URL 'ecomp.dol.gov/#/ca_1/step1' is visible.

DEPENDENTS

- Wife, Husband
- Children Under 18 Years
- Other
- None

WHO SHOULD REVIEW THIS FORM?

Immediate Supervisor's Email:

Select Email Domain:

Autosaved ●

Buttons: EXIT (red), > (blue)

Small text at the bottom: ACCESSIBILITY & 508 COMPLIANCE
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WHO SHOULD REVIEW THIS FORM?

If you do not know your supervisor's email address, just enter a current supervisor's first name and then `usps.gov` in the drop-down menu. That should be enough to get the claim processed.

10 Date: The last day you worked prior to your positive covid test

12: Occupation: Type Carrier and choose from Carrier City, Carrier Technician or City Carrier Assistant

#13: Cause of Injury

Type exactly this

Frequent high-risk exposure to coworkers and the public for 8+ hours a day 5/days a week while sorting and delivering mail. (If you are under light duty change the number of hours and days you work)

#14: Nature of Injury

Positive COVID 19 test on (date of lab test), with symptoms if any

DATE

Enter the last date that you worked and were exposed to other people in the work setting, **prior to the onset of COVID-19 symptoms or a positive COVID-19 test result**. Other people may include patients, members of the public or co-workers.

⑩ Date Injury Occurred (Date worked prior to COVID-19)

 (mm) (dd) (yyyy)

Time Injury Occurred (Time worked prior to COVID-19)

⑪ Date of this Notice

If you submit this form today, it will be filed on 12/30/2021.

⑫ Employee's Occupation

INJURY

Explain who you were exposed to in the work setting and the frequency and nature of those interactions. Include patients, members of the public or co-workers, etc. Do not include interactions while teleworking.

Cause of Injury - Exposure to COVID-19

⑬



(510 characters remaining)

Explain why you are filing this claim.

- Have you experienced symptoms you believe are attributed to COVID-19? If so, describe those symptoms and provide the date they began.
- Have you received a positive COVID-19 test result? If so what is the date of that test?
- If you have communicated with or seen a medical professional, describe that contact.

Nature of Injury - Explain why you are filing this claim

⑭



(250 characters remaining)

Witness

There is no need to fill this out

ecomp.dol.gov

CA-1 COVID-19 Claim

CA-1 filing help

Use this form only if you are filing a claim for COVID-19. Do not use this form if your claim is for a reaction to a COVID-19 vaccination. If your claim is for a reaction to a COVID-19 vaccination, use the standard Form CA-1.

ECN 10722880 | Draft

* This step is optional. If you have a statement from a witness who was present at the time of the event, you can upload that statement in the next step. Enter the witness information here. If you do not have a witness statement, you can skip this step by clicking the forward arrow below.

WITNESS (optional)

(16) Witness First Name Middle Name (optional) Last Name

Address

City State

Country

ZIP code UNITED STATES OF AMERICA

Date of Witness Statement (mm) (dd) (yyyy)

Autosaved

< EXIT >

Attachments

You can scan a pdf or take a picture (jpeg) of your positive Covid - 19 lab results and upload on this page.

Make sure the image you upload is readable.

Write and save the document control number, DCN in case it gets lost.

Note: if uploaded as “medical”, it will not generate a DCN, so upload it as “non-medical” to get a DCN.

If you have a problem uploading your test results you must wait until your supervisor completes their review and you get a claim number.

CA-1 COVID-19 Claim

[CA-1 filing help](#)

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ECN 10722880 | Draft

Upload a copy of a positive COVID-19 test result and any documentation from contact with a medical professional. If not available at the time of filing, upload within ten days of filing. Failure to do so may affect your entitlement to benefits, including Continuation of Pay (COP).

NOTE: Do not upload OWCP forms or medical bills here; they will not be processed. Medical bills should be submitted using OWCP's Central Bill Processing Center and OWCP forms should be submitted through your agency's established procedures (either electronically or in paper format). Forms or bills submitted as uploads will not be processed.

ATTACHMENTS (optional) [?](#)

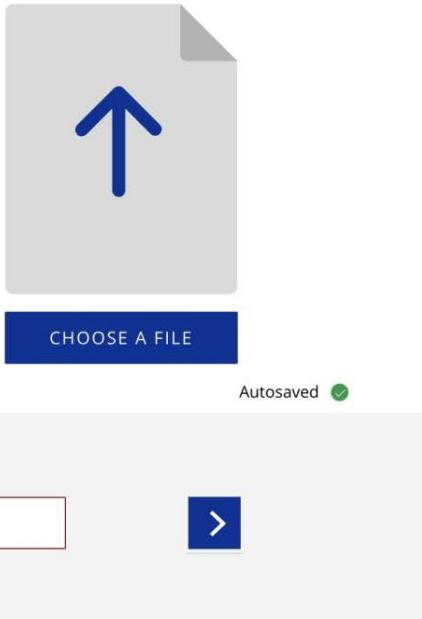
Max file size is 5MB

Limit number of pages to 20 per document

Allow 4 hours for processing

Upload one document at a time. Each upload is assigned a Document Control Number (DCN). 
Uploads will be converted to black-and-white.

Accepted file formats: jpeg, jpg, gif, png, txt, tif, tiff, rtf, pdf, doc, docx

CHOOSE A FILE

Autosaved ✓

< EXIT >

[ACCESSIBILITY & 508 COMPLIANCE](#)

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[CONTACT THE OFFICE OF INSPECTOR GENERAL.](#)

Choose COP, Continuation of Pay and sign

#17: Choose Continuation of Regular Pay (COP)

Then click on SIGN AND FILE

CA-1 COVID-19 Claim

[CA-1 filing help](#)

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ECN 10722880 | Draft

SIGN & FILE FORM

(17) 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.

Submitting this form is considered the same as signing it.



EXIT

SIGN AND FILE

Your CA-1 claim for Covid-19 has been filed!

Download a copy of the CA-1 to keep for your records

Check your email for verification

Check your ECOMP dashboard daily to track the status of your claim

This form has been forwarded for review.

UNITED STATES DEPARTMENT OF LABOR
ECOMP

HOME / EMPLOYEE HOME / CA-1-COVID-19

CA-1 COVID-19 Claim

CA-1 filing help 

Use this form only if you are filing a claim for COVID-19. Do not use this form if your claim is for a reaction to a COVID-19 vaccination. If your claim is for a reaction to a COVID-19 vaccination, use the standard Form CA-1.

ECN [REDACTED] Pending Review by Supervisor

 FORM LOCKED	ECN [REDACTED] CA-1 COVID-19	Pending Review by Supervisor
	Employee [REDACTED] Organization PUERTO RICO	Date of Event 12/20/2021 Initiated 12/30/2021
		View Upload Attachments Get PDF

- An email has been sent to your supervisor's email account at [REDACTED]@usps.gov
- You will receive email updates each time the status of this form changes.
- Make sure to save/print a copy for your records and note the ECN (ECOMP Control Number).

Next Steps

- After your claim is reviewed by your supervisor and is received by DFEC, you will receive an email providing a Case Number.
- You can use that case number to file a CA-7, claim for compensation.
- If you want to check on the status of your claim, visit your dashboard.

How would you rate the ease of your form filing experience?
(1 star very difficult; 5 stars very easy)

How could we improve the form filing experience?

(2000 characters remaining)

SUBMIT FEEDBACK

If you have problems with your claim, you are not getting paid COP, or your claim is denied, contact your NBA's office



NALC Region 6
43456 Mound Road, Suite 501
Sterling Heights, MI 48314
586-997-9917

Region 6 NBA David Mudd