

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-19

Choose your District

IA - NE - SD: 500-516, 520-528, 570-577, 680,
681, 683-693

KS - MO: 630, 631, 633-641, 644-648, 650-
658, 660-662, 664-679

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:

- 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 ✓

- 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

- Do Not Select State first
- Select Agency Group : Central Area
- Select Agency: Drop Down menu IA-NE-SD/ KS-MO
- Select Duty Station: IA-NE-SD (Sioux Falls) KS-MO (St. Louis)

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 browser window with the URL `ecompl.dol.gov/first_step1`. The form contains two sections:

- DEPENDENTS**: A section with four radio button options: "Wife, Husband", "Children Under 18 Years", "Other", and "None". The "None" option is selected.
- WHO SHOULD REVIEW THIS FORM?**: A section with two input fields. The first is a text box labeled "Immediate Supervisor's Email". The second is a dropdown menu labeled "Select Email Domain" with the value "eek. @dol.gov" selected.

Below the form, there is a green "Autosaved" indicator. At the bottom of the page, there is a footer with the text "ACCESSIBILITY & SQR COMPLIANCE" and "© U.S. DEPARTMENT OF LABOR, ALL RIGHTS RESERVED. PRIVACY POLICY".

- **WHO SHOULD REVIEW THIS FORM?**
If you do not know your supervisor's email address, just enter a current supervisor's first name.last name@ 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

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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)

Witness First Name Middle Name (optional) Last Name

Address

City State

ZIP code Country

Date of Witness Statement

Autosaved

< EXIT >

ACCESSIBILITY & 508 COMPLIANCE

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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.

BASICS INJURY WITNESS ATTACHMENTS REVIEW SIGN

CA-1 COVID-19 Claim CA-1 filing help

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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 >

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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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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](#)

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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 Initiated	12/20/2021 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 COP or your claim is denied, contact your NBA's office



Region 5 NBA David Teegarden

NALC Region 5
1828 Craig Road
St. Louis, MO 63146-4712
314-985-8040